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Analysis of Behavioral Programming for Alzheimer's and Other Dementia Clients:

Final Report
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I. Abstract

The primary aims of this research project were to prevent early institutionalization of impaired elderly persons and to improve their quality of life by training adult day care staff and families of the elderly to use behavioral procedures in the provision of care. The implementation of behavioral procedures in day care centers involved developing staff and family training packages designed to teach informal and formal care providers specific skills to help alleviate the behavioral and environmental problems associated with old age and chronic illness.

The beneficiaries of this research were adult day care staff, family caregivers and elderly persons over age 60 with behavioral deficits (physical and mental impairments) associated with old age and chronic illness, and who were currently participating in adult day care programs in Metropolitan Chicago. The research design use a single subject experimental design to evaluate behavioral learning by staff and improved behavior by the elderly clients. Pre and post tests of the elderly clients and family caregivers, direct observations of behavior, participant evaluations, and staff evaluations were the primary data sources. Demographic information was obtained using the OARS, a multidimensional assessment tool.

The training and research were conducted in five adult day care centers with 30 staff and 15 family members during the two year grant period. The program underwent major revisions as the experimenters developed a more realistic sense of the day centers time table and was conducted on site following a brief instruction period while staff were working with elderly clients. Staff were taught specific behavioral techniques in ten on-site training sessions, followed by five consultation sessions in which staff implemented and evaluated specific behavioral interventions for individual client problems. More specifically, staff were taught to identify reinforcing consequences, to use reinforcement, successfully analyze tasks, identify and use cues (prompts), implement contracts, develop client skills, apply procedures, and design and conduct group activities with clients. Following staff training, family caregivers were recruited for four group sessions design to teach rudimentary behavioral techniques.

The results of the research project, clearly demonstrate that staff were able to use behavioral techniques which resulted in behavioral improvement in selected behaviors of clients. These findings, however, suggest that the caregiver's involvement in training and adult day care is difficult to obtain and that although family training in previous home-based research was useful, cooperation in a four session group training program in the day center was impossible to achieve on a large scale. Further, this research contributed to our understanding of the difficulties involved in coordinating family (informal) and day center (formal) resources in a consistent way to enhance the social functioning of the elderly. Results of behavioral training of staff benefited the elderly clients by reducing confusion, increasing positive activities, and increasing client opportunities to receive positive consequences in the day centers..

II. Final Report

1. Objectives

The primary aims of this research project were to prevent early institutionalization of impaired elderly persons and to improve their quality of life by training adult day care staff and families of the elderly to use behavioral procedures in the provision of care. The first objective of the research was to develop and evaluate a training program for adult day care staff in behavioral management techniques to enhance the social functioning of impaired elderly clients in adult day care. The second objective was to generalize behavioral techniques to train family caregivers of impaired elderly clients in adult day care to manage behavior problems.

The research questions were designed to examine the generality of previously successful behavior modification procedures used with seriously impaired older persons in nursing homes to day care (Pinkston & Linsk, 1984). More specifically, the research addressed the following questions:

1) How can informal supports (family based care) and formal supports (adult day care) supplement each other to assist older persons with severe behavioral problems resulting from Alzheimer's and other dementias?

2) Will this combination encourage continued structured at-home care as an alternative to long-term institutional care?

3) What are the cost implications for families and providers of substituting home- and day-center-based services for residential care?

4) Can behavioral change in either setting be transferred to the other setting? Can extension of educational procedures from the behavioral literature be effective across multiple settings?

5) Are procedures developed and evaluated in research projects to teach families to treat behavioral problems at home appropriate for day care staff?

6) What is the result of using these procedures on family caregiving patterns, use of other services, and long-term care placement?

7) What are effective uses of reinforcement and stimulus control techniques in helping to alleviate behavior problems of older persons in family and service settings?

These questions are particularly important to service providers, practitioners, families, and gerontologists, due to the limited resources and increased awareness of limitations of long-term care arrangements and an increasing population of older persons with intellectual and behavioral difficulties. More specific programs are needed to help families deal with problematic behavioral patterns and to integrate efforts by families and formal service providers.

Previous research has indicated the usefulness of behavior modification both to older persons and families of younger persons with behavioral difficulties and their families (for a review see Reidel, 1981). The potential for applying behavioral procedures as an independent intervention to problems of older persons has seldom been systematically evaluated. Initial studies carried out by the authors (Pinkston & Linsk, 1984 , 1984b; Green, Linsk & Pinkston, 1986) developed and tested a short term intervention model that has been helpful in improving specific behavior problems, forestalling or avoiding institutional placement, and improving family caregiving.

Adult day care has emerged as a viable alternative to institutional care. Community based adult day care centers provide clients with needed services and with opportunities to be with with others with similar social and recreational interests. To be effective, adult day care centers need caregiving staff skilled in providing services and in facilitating clients' involvement in desirable, meaningful activities.

The number of adult day care centers in the United States increased from 15 in 1974 to 1500 in 1983. This increase has highlited the need to ensure that staff at such centers are trained to give effective client care. Conscious of both costs and the need for good client care, agency administrators are likely to see as most desirable those training programs that are cheap, take as little time as possible, are minimally disruptive of agency routine and, are effective in training staff in needed skills.

With that in mind the Elderly Support Project (ESP) staff designed a training program that would: a) teach agency staff the techniques necessary to be effect caregivers; b) minimize the amount of staff work time and other agency resources needed to conduct the training; and c) maximize incorperating training into staffs' and agency ongoing activities.

The theory used as the basis for this work was primarily operant with some observational techniques drawn from social learning theory (Pinkston & Linsk, 1984). Basic to operant theory is the "law of effect," which refers to the likelihood of a recurrentce of an individual's behavior under similar circumstances. The likelihood of a recurrence of a behavior increases or decreases depending on the consequences of that individual's actions. Those behaviors that are associated with desirable consequences are strengthened (Pinkston, et al., 1982; Redd, Porterfield, & Anderson, 1979).

The principles of operant theory address the reistionship between a behavior and the environmental events that are presumed to control that behavior. Although operant theory is generally associated with the effects of the consequences of behavior, antecedent events are also recognized as being related to the occurrence of behaiver. Lindsey (1964) specifies four stages of the "functional analysis of behavior": the antecedent stimulus or stimulus setting in which the behavior occurs; the actual behavior of interest; the contingencies of reinforcement; and the environmental event that follows the behavior.

The model in this research used only the reinforcing consequences of behavior and none of the punishing consequences for several reasons. First, it was decided that the training would focus on staff and client task performance rather than on problems. This would focus attention on client and staff skills and accomplishments and away from staff and client deficits. Since the intention was to enhance skills and task accomplishments, that is, to increase desirable behavior and outcomes, reinforcing consequences had to be used.

An additional reason for using only reinforcing consequences in the training program centers was to respect the autonomy of the staff and clients. It did not seem proper to use punishment (negative consequences) simly because one did not perform as had been wished. Therefore, punishment was excluded from the training. There are more practical reasons for not using punishment, of course. It leads to avoidance behavior and resentment and one may be modelling the very techniques one wishes to avoid teaching.

The training literature indicates that effective behavioral staff training produces caregivers who have the knowledge and skill to be effective caregivers (Hussian, 1981; Kazdin, 1980). Institutional staff training methods have included the traditional approach of employing verbal, visual or written techniques such as lectures, discussions, and the use of reading materials, films and slides (Hersen & Bellack, 1976; Kazdin, 1980). These methods are essentially informative and are useful for increasing knowledge about general behavioral principles, and also appear useful for learning about intervention techniques and procedures (Cuff, 1977; Dolmeter, Connerr, & Wells, 1984; Gardner, 1972; Schinke & Wong, 1977).

Studies show that these methods have little or no effect in developing applied skills (Bernstein, 1984; Dolmeter, et al., 1984). Staff training methods which have been found effective for teaching behavior change skills including modelling, in which the desired behavior is demonstrated and is observed by the trainee (Gladstone & Spencer, 1977), feedback, the process of providing someone with information about that persons performance to guide subsequent performance (Parsonson, Baer, & Baer, 1974), reinforcement, a procedure that strengthens the tendency of a response's recurrence (Dolmeter, et al., 1984), and various combinations of these methods.

This model was designed to be implemented on-site to avoid the problem of generalization (transfer of learning) from one setting to another. It also taught staff specific skills and evaluated them before going on to the development of interventions with elderly clients (For an examination of generalization issues see Chapter 9 in Pinkston, et al., 1984).

2. Program Sites

The Elderly Support staff of the University of Chicago's School of Social Service Administration conducted the research in five adult day centers in Metropolitan Chicago during the two year funding period. Initial start-up arrangements were made during an orientation meeting with the directors of each adult day center. A package outlining the proposed project was presented to all of day care centers who expressed an interest in staff training. Afterwhich a meeting was arranged to discuss centers' involvement in the research project. The administration of five centers agreed to participate in the behavioral management training program.

Description of Participating Adult Day Centers

All the centers were private non-profit organizations and three centers were primarily funded by the State of Illinois. In all cases both clients and staff were representatives, both socio-economically and ethnically, of the communities serviced by the adult day centers. All centers represent a social model where services are designed to facilitate social interaction among the participants. Services provided by

the centers usually include nutrition, education, daily physical exercise, counseling, and family respite. The five centers participating in the research project were:

1. Chicago Commons ADC
   6308 South Loomis
   Chicago, IL
   Director: Dorothy Gibbs

2. Bethel New Life ADC
   4745 W. Rice
   Chicago, IL 60624
   Director: Wanda Lewis

3. House of Welcome
   914 Lincoln
   Winnetka, IL 60093
   Director: Shelly Sincox

4. Southwest ADC
   2800 W. 95th
   Evergreen Park, IL 60642
   Director: Jean Kryounc

5. Suburban ADC
   149 W. Harrison
   Oak Park, IL 60304
   Director: Mary Hagerty

In each case both participants and staff were representative of their communities, both socio-economically and ethnically. All the sites provided such generic services as transportation, social/recreation, education, continuous supervision, nutrition (lunch and snacks), information and referral and personal care. Each setting represents a micro-community of cultural richness. Below is a brief description of each center.

The ADC program for Chicago Commons provides services to the elderly and their families located in the Southwest Chicago area. The program is staffed by an executive director, 9 staff members and 2 volunteers. The total enrollment of elderly participants is approximately 55 with an average daily attendance of 31. All participants are black.

The Bethel New Life ADC provides services to the elderly and their families located in West Central Chicago. The program is staffed by an executive director, 2 program assistants, a bus driver and 2 volunteers. The average daily attendance at the center is approximately 20 black elderly participants, with a total program enrollment of 30.

The House of Welcome is adjacent to and subsidized by the North Shore Senior Citizen Center. The staff consists of the director, three (3) program assistants and eight (8) volunteers. Of the twenty (20) white participants, one-hundred percent (100%) have Alzheimer's or related disorders. Like the other sites, the participants attend the program 3 to 5 days per week.

The Suburban ADC is staffed by the director, the program coordinator, the assistant program coordinator, and a program aide. Approximately fifty-percent (50%) of the twenty-five (25) participants have Alzheimer's or related disorders. One-third (1/3) of the participants are black.

The Southwest ADC is housed in Evergreen Park, a suburb of Chicago. It is staffed by an executive director, a program director, 2 program assistants, and 3 social work interns. The entire population of 10 clients have Alzheimer's or related disorders. The participants attend 3 to 5 days per week. Seventy-five percent were white and twenty-five percent were black.

A hispanic center was initially part of the sample but was discontinued when our Spanish speaking staff member was unable to continue and could not be replaced.

Sampling Criteria

The clients in this research were restricted to those with a caregiver to allow generality testing of the behavioral parent training research. Specific referral criteria were established for this project and distributed to day center staff. The initial criteria for selection were (a) clients over 60 years of age; (b) diagnoses include severe psychological problems and/or brain dysfunction including chronic and acute brain syndromes, reactive mental disorders, depressions that would otherwise prevent community functioning, schizophrenia, senile psychosis, paraphrenia, arteriosclerotic brain disease, acute confusional states or physical impairments such as cardiovascular accidents, arthritis, fractures, or spinal cord injuries; (c) the client function at excessive disability, that is, funcitonal disability is greater than warranted by their health status (Kahn, 1963); (d) caregivers include family or others to participate in behavioral change efforts; (e) behavioral excesses or deficits in rates of appropriate or inappropriate behavior, family interaction dysfunction, interpersonal problems, communication difficulties, social isolation, or inability to engage in activities of daily living; and (f) low rates of interaction with community activities or services.

The following criteria were used to determine the caregivers' ability and willingness to participate in the change effort: (a) available with adequate time for involvement with the program; (b) adequately motivated, that is, affected by the behavior of the client; (c) adequate access to client and control of some behavioral consequences; (d) relationship with the client that involves ongoing contact; (e) adequate skill levels or ability to learn skills; (f) adequate mental and physical health; and (g) accepted to community care program or willing to enroll and pay for day care services.

Regarding the staff selection criteria, all staff members who worked full time at the day centers and or who had direct contact with ADC participants were considered appropriate for the training program. While participation in the training program was encouraged, all participation was voluntary.

3. Methods

The research design for this program included single subject experimental designs to evaluate and compare changes of clients within adult day centers and between clients of different day centers. Pre and post test surveys assessed related changes and the responses of the elderly family members and staff. This design also allowed the program to assess the effectiveness of staff using specific behavioral procedures such as rein-forcement and stimulus cueing (Pinkston, et al., 1982; Pinkston & Linsk, 1984) as well and their effectiveness with specific problems. Below is a brief description of the variety of measurement tools used to collect data.

Direct Observations

Direct observations of elder of elderly client's behavior and interaction between staff and clients several as data sources for the study. Two kinds of observational data were included: (1) continuous time sampling procedures to assess baseline and post-intervention interactions between staff, family, and elder persons; and (2) family and

staff recorded instruments which monitored the frequency of specific targetted behaviors. A family behavioral record is included in the Appendix as a general instrument to record daily behavior frequencies. At the end of the ten training sessions a structured observation system was used to evaluate the staffs' skills at implementing the operant procedures. This assessment tool consisted of nine structured activities, each oriented towards a specific set of the operant techniques used to deal with the elderly.

Structured Assignments

The implementaion of a structured observation system was used by the trainer to evaluate the staffs' use of the behavioral procedures in the natural environment. Standarized situations consisted of structured tasks oriented toward the operant techniques taught to the staff. During this phase of training the staff member was asked to follow instructions for a brief structured activity. The trainer at the same time used an observtion system to record the staffs' response. Structured evaluations allowed the trainer to determine whether or not the staff developed the skills necessary fer designing and implementing a behavior intervention.

Pre and Post-Questionnaires

Other data sources included pre and post-test assessment survey of staff and family caregivers. A questionnaire used in previous research, the OARS Multi-Dimensional Assessment Instrument (1978) was administred to caregivers at two points in time, at the beginning of training program and at the end. The appropriate demographic data were recorded to allow comparison between cases. Specifically, an Older Persons Pretest Questionnaire, a Support Person Pretest Questionnaire, and Staff Agent Pretest Questionnaire were administered. (See Appendix B for Instruments).

Behavioral Assessment Tools

Behavioral management tools provided additional data, including a visit checklist, a telephone checklist, and activity logs to monitor the time spent in various activities and how specific techniques and procedures were implemented (See Appendix C for Behavioral Assessment Forms).

4. The Staff Intervention (Training) Model

The basic model tested was a short term behavioral intervention model. Training, evaluation, and assessment occurred within 10 on-the-job sessions, and 5 consultation sessions which involved designing and implementing an intervention with targeted clients. The intervention model included several steps: 1) Group instruction sessions which focused on teaching the staff how to use operant procedures including: principles of reinforcement, task analysis of client behavior, cueing, activities programming, behavioral contracting, group skills, differential reinforcement of incompatible behaviors, and skill development; 2) on-site training sessions which involved an unstructured observation of the staff in the adult day setting and provision of corrective feedback and reinforcement; 3) structured observation system used to evaluate the staffs' skills at implementing the operant procedures; 4) development, implementation and single case evaluations of behavioral interventions for targeted ADC participants; and 5) development of maintenance procedures. Project workers used instructions, feedback, and modeling as well as

instructional materials to teach day care center staff to implement behavioral procedures. Each of these variables were used to effect changes in behavior on the part of staff and changes in the day setting to promote more positive client behavior.

Staff Training

The staff training model described above includes a combination of group instruction and on-site training. Group instruction occured formally once a week for fifteen to thirty minutes. Written exercises, oral explanations, and checklists relating to procedural strategies were presented during this time. In addition, questions raised by the ADC staff were answered. Written exercises and verbal explanations included a progression of cumulative steps leading to the goals of having the staff members design, implement, and evaluate a behavioral intervention for targeted ADC participants. During each week of training the trainer requested the completion of written exercise and behavioral responses from the staff who were practicing these procedures. Group instruction included several steps:

1. The trainer each week observed the ADC staff members in their 'natural' working environment. The trainer identified examples of the staffs' use of stimulus conditions which would require the staffs' future use of the operant procedures being taught that week.

2. ADC staff then met formally with the trainer, once a week for 15-30 minutes during the ADC operational hours. At this time, learning activities were discussed.

3. Staff identified reinforcers and reinforcing activities for targeted ADC clients.

4. Staff used reinforcement principles with targeted clients.

5. Staff developed skills for completing a task analysis of client behavior.

6. Staff learned how to cue ADC clients for specific behavior.

7. Trainer and staff developed activities program which would promote opportunities for positive behavior from clients.

8. Staff used behavioral contracting.

9. Trainer taught staff techniques which would assist staff in increasing client interaction and postive behavior during group activities.

10. Trainer taught staff differential reinforcement of incompatible behaviors.

11. Trainer taught techniques that would assist the staff in helping a client establish or relearn a skill, i.e., using eating utensils at lunch.

Task assignments and worksheets were distributed once a week (See Appendix C & D). The trainer offered a clear specification of the assignment goals during the formal training session. The trainer specifed the criteria for success emphasizing clearly defined sub-tasks and the staff's use of a behavioral task checklist. During

these sessions the trainer tried to shape the staff's behavior by using positive reinforcement and imitative prompts such as modeling, rehearsal, and coaching.

During the same week, the trainer conducted an on-site training session. On-site training in this program refers to an unstructured observation in the natural environment of the ADC center. On-site training was used to teach adult day care staff to use behavioral techniques by cueing and praising the staffs' appropriate use of operant procedures learned as a results of the staffs' completion of task assignments. During the on-site training sessions the trainer observed a targeted staff member working in the ADC center. While observing, the trainer waited for the targeted staff member to interact with an older client. The staff member asked questions, conducted a group activity, ignored, responded, assisted a client, or engaged other ADC clients and staff.

The trainer needed to make appropriate decisions while observing the staff member. During the observations the trainer assessed the on-site training situation by referring to the task assignment checklist. Any use of the assigned tasks skills discussed during the formal training sessions was noted. If the trainer observed the correct use of the behavioral procedures she confirmed the staff member's behavior and verbally provided positive feedback. If the trainer did not observe the skill or use of the assigned procedures, she made a decision concerning her cue to initiate instruction. Positive feedback was always offered regardless of the staff member's difficulty implementing the procedures.

Retraining of the staff member was used when the individual was having great difficulty demonstrating the skills or completing their written assignment. Retraining also occurred when the staff member had not responded to cues used by the trainer. Here, the trainer modeled the techniques when she was sure that the staff member did not know what to do or was unable to determine what the staff member was trying to accomplish during the observations. The trainer then modeled all or part of the task assignment. Thereafter, the trainer asked the staff member to rehearse the tasks. Again, positive feedback was administered throughout the retraining sessions. Since these procedures were foreign, especially to paraprofessional staff, it was essential that the trainer provided positive feedback to avoid increasing anxiety of the staff.

5. Family Training

The family training model provided instructions designed to assist the caregivers in learning how to : (1) operationally define behavioral deficits and excesses, (2) monitor behavior using observation and data collection techniques, (3) graph data, and design, implement, and evaluate a behavioral intervention. The training also provided an opportunity for the caregivers to learn how to monitor, evaluate, and increase their own reinforcing activities.

The training model consisted of 4 1-1/2 hour group training sessions. After the complete implementation of the Behavior Management Training Model with staff at the day care centers, family training was initiated at two of the five centers. All family caregivers in these centers were offered the opportunity to participate through the day center administration. (See Appendix for recruitment procedures.) A total of 15 family members of the impaired elderly day care participatants began the training sessions.

During the initial training session, the trainer completed the following tasks: (1) explained the primary aims of the Elderly Support Project and a rationale for

training; 2) outlined the trainer's and caregiver's task responsibilities; 3) provided an explanation about the data collection techniques; and 4) distributed pre-test instruments (See Appendix E for outlines of session). Also, during this session the trainer briefly reviewed the skills to be taught and stressed the usefulness of the behavioral methods and how the clients and their caregivers could benefit using these techniques. Examples were drawn from the previous success cases from the Elderly Support Project's work in the community and in the day centers. Caregivers were then given a demographic face sheet to complete.

Homework tasks were assigned during each session because of the limited amount of time. These task assignments involved recording observation data, completing a reinforcement survey with the carereceiver, and the caregivers' completion of a caregiver efficacy survey. Training was then followed by a phone call to each of the caregivers' homes. Phone calls were arranged to provide reinforcement, answer questions, provide feedback and clarification to those who were having difficulties, and to remind caregivers of the next scheduled training session.

The second training session was structured to evaluate the baseline data collected during the previous week, help the caregiver select and design an intervention, teach and help the caregiver practice the behavioral procedures, and help the caregiver analyze his/her own involvement in reinforcing activities. Behavioral principles emphasizing the uses of reinforcement, reinforcement of incompatible behaviors, cueing, ignoring, and praise were presented. Caregivers were also trained to use contracting as a tool for increasing appropriate behavior and decreasing inappropriate behavior. The trainer outlined the decisions on the types of interventions to be used, when the interventions should be carried out, and specification of the types of social and material rewards.

The third and fourth training session were structured primarily to review, assess and refine the caregivers' progress and satisifaction with their intervention plan. This session was also designed to help the caregivers target future behaviors on which to intervene.

6. Staff Behavioral Management Training Program Results

The data analysis supports the effectiveness of the staff training procedures for teaching ADC staff the skills necessary for conducting behavioral assessment and intervention. A total of 21 staff members at three adult day care centers completed the training program. A demographic analysis of these staff members revealed the following:

- The mean age of the staff is 42 years, with an age range from 23 to 71 years.
- The staff members were primarily female (90%).
- The average educational attainment for the staff was 13.5 years, the equivalence of 1 1/2 years of college.
- The staff, on the average, had been working in adult day care for 3 years.
- Finally, the staff members were primarily black(86%) and the remaining 14% were white.

In order to assess the effectiveness of the training, pre and post tests were administred to the 21 staff members at three centers. Included in the assesment were structured assignments on reinforcement, task analysis, cueing, and behavioral contracting. Staff were asked to complete four structured assignment before training and again 6 months later, after training. Below are the results of the pretest and posttest scores.

Reinforcement

Results of the pre and post scores for the reinforcement tasks are presented in Figure 1. The staff members were asked to use reinforcement principles with targeted clients before training (pretest) and after training (posttest). As illustrated in Figure 2, there was a significant improvement in staff performances from pretest to posttest. Staff improvement scores, the difference from pretest to posttest, ranged from 20% to 60%, with the majority of the improvement scores clustering around 40%. Hence, Figures 1 and 2 indicate that after being taught reinforcement techniques, staff members were able to successfully identify reinforcers and reinforcing activities for elderly clients and apply reinforcement principles with targeted clients.

Task Analysis

Figures 3 and 4 presents the results of the pre and post scores of the staff member's performance on completing task analysis. Task analysis involves simplifying a chain of behaviors into sub-behaviors. The task analysis is written and clearly specifics each behavioral step the client must complete inorder to accomplish the desired target behavior. Additionally, a task analysis must detail the staffs' sub-skills required for enhancing the client's chain of behaviors. Staff were asked to select a client and a target behavior and complete a task analysis plan At pretest, before training, the majority of the staff correctly completed less than 40% of the task analysis plan. However, at posttest, after training, the majority of the staff correctly completed 80% to100% of the task analysis plan. In terms of improvement scores, the difference between pretest and posttest, the score range was from 40% to 100%, with an average improvement score of approximately 60%. Comparatively, staff performed better on the reinforcement task both at pretest and postest than on the task analysis plan. But, the improvement scores from pretest to postest were higher for the task analysis plan than for reinforcement. These findings suggest that the training intervention was successful in teaching staff how to develop and implement a task analysis plan.

Cueing Task

Figures 5 and 6 present the results of the cueing task correctly performed by the staff. Cueing is the presentation of a stimulus, i.e. verbal directions, or material prompts, which increase the likelihood that a target behavior will either occur or cease at a certain time in a certain place. At pretest, the majority of the staff were unfamiliar with cueing and conse-quently had difficulty completing the task. Figure 5 shows that the majority of the staff correctly completed less than 40% of the cueing task. Whereas, at posttest, most staff correctly completed100% of the cueing task. Thus, indicating that once staff were taught to cue targeted behaviors, they were able to significantly improve their scores when evaluated six months later.

Behavioral Contracting

Figures 7 and 8 present the results of the behavioral contracting correctly performed by the staff. Contracting involves a joint agreement designed by two parties, i.e., adc participants and adc staff member, which defines who is involved, stipulates what behavior is expected from each party, when the behavior is scheduled to occur, where the behavior is to occur, and what reinforcer will be administered when the behavior occurs. Staff members were asked, at pretest and posttest, to design a contract for a specific behavior with a selected client. Figure 7 shows that overall staff performed signifcantly better at posttest than pretest. Interestingly, at pre-test, several staff correctly completed 60% to 70% of the behavioral contracting assignments, indicating their familiarity with the skill. For these staff members, the training ehanced their previous skills, resulting in superior scores (100%) at posttest.

Overall, the staff performed better at posttest than at pretest, indicating that the training program was successfull in teaching staff to use behavioral techniques with selected client behavior. Figure 9 shows the improvement of staff from pretest to postest by centers. There was very little difference between centers. Cueing and task analysis represented the largest increase between pretest and posttest for the three centers, indicating that these skills were either more difficult for staff at pretest or that staff were more successfull with these skills at posttest. In addition, for center 3, behavioral contracting represented a significant increase between pre and post scores. Clearly, reinforcement was the only skills that did not receive as large as a percent increase as the other skills. This is probably due to the fact that staff members' scores for reinforcement at pretest were better than their scores at pretest for the other skills, coupled with the fact that seventeen staff members completed 100% of the reinforcement task correctly.

Case Summaries (Examples of Interventions, Figure 11)

Case 4041. Figure 9a.

1. Identifying information. This is an 86 year old white male with neuromuscular damage resulting from a stroke and emcerbated by arthritis, and Parkinson's disease. He in totally dependent on a wheelchair for mobility. He has a hearing impairment, but hearing has significantly improved with the use of a hearing aid. The client needs help and regular assistance with 12 of 13 Activities of Daily Living. Also there is some memory loss, he scored 60% on the MSQ.

2. Presenting problem. The client rarely participates in group activities. During group activities, he sits in his wheelchair with his head bowed and eyes closed.

3. Behavior to be increased. The overall goal of the intervention was to increase the client's participation in group activities. More specifically, the client will participate in one morning group activity and one afternoon group activity five days a week (the client attends the center monday thru Friday).

4. Recording procedures. The Staff member will monitor the client during the group activities. If the client participates in the activity for at least 5 minutes, she will record using a "1" indicating that the client achieve the goal. If the client participates for less than 5 minutes, the staff will record using a "0" indicating that the goal was not acheived.

Data will be recorded for each day that the client is at the center.

5. Baseline procedures. The staff will monitor and record the number of times the goal was achieved, the length of time the client participated, and the name of the each activity for one week.

6. Intervention plan.

A. Elderly Reinforcement Survey Schedule. The reinforcement survey was completed on the client as a prerequisite to developing the intervention plan. The staff used the survey to assess what kinds of activities the client enjoyed. The results of the survey indicated that the client enjoyed playing various games, watching T.V., reading the newspaper and magazines, and playing with animals, especially puppies and cats. This information was helpful to the staff in identifying the kinds of activities that should be strong motivators for engaging the client or the activities in which the client is more likely to participate. Also, staff can use this information in developing additional activities for the clients or use the survey information to plan individualized activities for clients.

B. Contract. A written contract was completed in which the client agreed to participate for 5 minutes each morning and afternoon in a group activity. When the client participates for the agreed on length of time, he will receive verbal praise and a star for each activity. At the end of the week the 10 stars will be traded for a scenic stroll around the facility with the staff member.

C. Cueing. The staff member will remind client of the contract and indicate that she would like for the client to participate in the upcoming activity. The staff member will instruct the client how to perform the task, and then allow the client to carry out the instructions.

7. Results. The data indicate that the client did not participate in group activities held in the mornings during baseline. However, the client did participate in group activities held in the afternoon, albeit some what inconsistently. Thus, the goal for the intervention was slightly modified to increase participation in the morning activities and to increase consistency of participation in the afternoons. The intervention plan, however, was not modified.

During the intervention phase, the client participated in all five of the designated morning group activities. These activities were: 3 current events group discussion and 2 exercise classes. Likewise, the client participated in all five of the designated afternoon activities. These activities were: 1 baking cookies, 3 bingo, and 1 exercise class. In each activity the client receive verbal cueing regarding the length of time he participated in the activity, verbal reinforcement and a star. At the end of the week long intervention phase, the stars were traded in for a wheelchair stroll in the facility.

Case Summary 1011 (Figure 10)

1. Identifying information. This is a 77 year old black female who scored 60% on the MSQ. She is in good physical condition. She attends the center three days a week.

2. Presenting problem. (a) Staff reported that the client acts aggressive and hostile towards a specific male client. She makes negative comments about him, such as

"criticizing" and "putting him down". This behavior usually elicit laughter from other clients and retaliation from the male client. (b) In general the client's interaction with other client usually consisted of negative comments.

3. Behavior to be increased. (a) Client will increase the number of positive comments made to the male client in question and (b) to the other clients in general.

4. Recording procedures. The staff will observe the client behavior for 30 minute intervals during the day. The observations were conducted at: 10:30-11:00, 11:30-12:00, 12:30-1:00, 1:30-2:00, 2:30-3:00, and 3:30-4:00. The staff member recorded both positive and negative comments made to the male client and positive and negative comments made to the other clients.

5. Baseline procedures. The staff member will observe the client during the designated times and count the number of positive and negative statements made about the male client and others.

6. Intervention plan.

(a) Behavioral Contract. A written contract was completed in which the client agreed to compliment the male client once in the morning and once in the afternoon for one week. When the client accomplishes the goal, she will be selected Senior of the Week. Once she is selected Senior of the week, her picture will be taken and posted so that all the staff, family members, clients, and visitors will know of her accomplishment.

(b) Reinforcement. When the client makes a positive statement about another client the staff will reinforce the client by commenting on how nice of her to say that about Mr. X or Mrs.

6. Results.

Improvement resulted in both areas. The client increased her positive comments about the male client and about clients in general. During baseline the client make all negative statements and no positive statements about the male client and others. During intervention,however, the client significantly increased positive statements.

It appears that the reinforcement used in the contract was extremely effective. The client was excited about the possibility of being named Senior of the Week. As such, she needed very little cueing during the
week long intervention.

Behavior Principles Inventory

Figures 12 and 13 show improvement on the Behavioral Principles Inventory in 20 of 21 staff members between pre and post tests. This improvement was highly variable and was not correlated in any meaningful way with scores of improved behavior.

Difficulties Encountered

The major source of difficulty for this research and training project was primarily related to implementation problems. Although approval had been obtained from directors of the centers before the grant application was approved, additional key personnel, executive directors, boards, and area supervisors had to be consulted. Consequently, it was several months before trainers could initiate the training sessions. Below is a detailed discussion of the various conflicts that interferred with the project's proposed timeframe and prevented staff members and families from attending training sessions.

Once the pretest questionnaires with families and clients and behavioral observations of staff and client interactions had been completed, training was initiated at the Southwest ADC in late August of the first grant year. Preliminary problems that occurred at the Southwest Adult Day Center were related to administrative and organizational matters. First, during the third training session, there was a 100% staff turnover, including the center director. Consequently, the trainining program was temporarily suspended and suffered serious delays until a new staff could be hired and oriented to the agency. The training did not resume until January of the following year. Once training was reinstituted, the trainer was then confronted with staff dropping in and out of training due to the hiring and firing practices of the center. The constant changes in staff made it extremely difficult for the training program to adhere to the proposed timeframe and seriously compromised the progressive skill building nature of the training design. Thus, the project director and the center director of Southwest ADC, in several problem solving meetings, decided that the training program should be terminated for the first grant year and resume during the second grant year. This would allow the center the time to work on organizational problem and also stabilization of its staff. Hence, training was reinitiated in December, 1986 and completed in March, 1987. A total of four staff members successfully completed the training program, in additional to 3 staff who participated in the program at various stages, but did complete the program due to termination of employment.

Albeit the training program encountered difficulties at Southwest ADC, once the administrative problems were solved the training program was extremely successful. (see the sections of results for supporting data). However, this was not the case at Casa Central. Casa Central is a Hispanic social service agency which adult day care services to older impaired Hispanics. Before the grant application was accepted, the Principal Investigator and the Executive Director of Casa Central met to discuss the possibility of developing a collaborative relationship. It was agreed that the training project could be implemented as long as the trainer was fluent in Spanish. The project recruited a Hispanic social work doctoral student to serve as a trainer for Casa Central. Once training had been initiated, the trainer, due to personal reasons, was unable to continue the training. Hence, training was terminated until a replacement was found. However, efforts to locate a trainer who was bilingual and skilled in behavioral technology were unsuccessful. Consequently, the project was unable to continue the training program in this center.

In addition to the implementation problems mentioned above about specific centers, other difficulties encountered can be generalized across most of the five centers. Below is a brief account of these problems.

- For all the centers, incorporating the training program into the ADC center was hampered by the staffs' anxiety. This anxiety

was due in part to staff beliefs that they were being evaluated and evaluation results would be shared with the group and top level administration.

- Other implementation barriers were the language used by the trainer and the educational levels of the staff. Behavioral terminologies used throughout the program were not common to the paraprofessional staff. Moreover, staff indicated that they knew what the words meant, yet had some initially difficulty in understanding how to transfer the defined concepts into practice. Also, some staff also had difficulty with the written tasks. Staff reported that they had been out of school for several years, and the homework requirements provoked anxiety. In order to allay anxiety, the trainer praised all efforts at completing the task assignments and also tried to use words common to the staff. In addition, she modeled all techniques and coached the staff while they rehearsed the learning activities with other group members.

- Morale problems occurred among the staff at three of the centers due to low salaries, voluminous work responsibilities, unavailable job promotions, and limited vacation time. Hence, contingencies that would normally reinforce the staff for their job performance were unavailable.

- Staff members were reluctant to attend meetings when they had not completed their task assignments or when they had difficulty understanding the assignment. The staff reported that evaluating and describing their job performance on paper was especially difficult and too time consuming.

- Several problems arose with the on-site training sessions which required the staff to work with clients while the trainer observed. Some staff members were concerned about being observed and evaluated on their performance. The trainer attempted to reduce their fear by assuring the staff that her observations would be kept confidential and that the individual results would only be shared with the observed staff member. The trainer also indicated that all results would be coded and only the aggregate results would be presented to the group during training.

- Finally, staff absences also presented problems. Thus, requiring the trainer to make several trips in order to successfully complete on-site observation or a training session. Telephone calling prior to conducting these sessions proved to be ineffective.

Similarly, the family training component encountered difficulties that interferred with the implementation of the project. Although, we did not train as many family members as we initially proposed, fifteen (15) family members were trained by the project. Though a participation rate of 15 may seem low, it is higher than the number of family members participating in other family programs at the individual centers. Center directors often complain about been unable to maintain a support

group due to families not attending. On the average, 3 to 5 family members can be expected to attend on-going family programs at these centers. The situation suggest that efforts focusing on identifing and removing barriers to family participation are essential. Below is a brief description of the problems which interferred with caregivers participating in the training program. The list is not meant to be exhaustive, but represent the most recurring problems.

- No transportation
- Scheduling problem
- No time available
- Too tired
- Child care responsibilities
- The elderly client doesn't like to go out at night
- Health and disability problems
- Caregiver wants to be alone with client at night
- No on to leave elderly client with at night
- Elderly client goes to bed early
- Caregiver goes to school, work, church etc.
- Too much of a burden to transport the elderly client
- Not interested
- Training would not be beneficial

III. Dissemination and Utilization

The Elderly Support Project has encouraged the use of the results of this research project to a variety of appropriate users in different geographical areas. Our intent was to insure that the products of this project were practical and useful to adult day care centers, gerontologists, practitioners, families, Area Agencies on Aging offices, service providers, educational institutions, and the general public. Below is a list of all dissemination efforts according to type of dissemination and the geographical audience served: Chicago, state, regional and national.

Magazine Article About Elderly Support Project:

Simon, C. (1988). A care package. Psychology Today, 22, 4, 42-49.

Chicago

Chicago Association for Behavior Analysis Workshop, October 10, 1986, "Training Staff in Adult Day Care Programs," at workshop titled, "Understanding Behavior Management for the Care of the Elderly," sponsored by Elderly Support Project, University of Chicago.

Illinois

Association for Adult Day Care, Behavior Management in Adult Day Care, Elsie Pinkston present in both in Chicago and Springfield Training Workshops, 1986.

Regional

Colloquium, "Developmental Research in Applied Settings, March 4 1987, University of Pennsylvania, philadelphia, PA.

Midwest Sociological Conference, April 1987, Chicago, IL, "Exploring the Positive Consequences of Caregiving in Black Families", April 1987, Earlie Washington; and "Informal Family and Church Supports of Caregivers of the Frail Elderly in Black Families", April 1987, Brenda McGadney

National

Charlotte Towle Symposium: Behavioral Research on Aging, November 17-18, 1986, The University of Chicago, Chicago, IL. Chair: Elsie M. Pinkston

1. "Dependency in the Elderly: Its Role in the Process of Successful Aging", Dr. Margret Baltes, Free University Berlin, West-Germany
2. "Detection of Psychological and Behavioral Problems of the Elderly", Dr. Stephen Rupp, Veteran's Administration Medical Center, Jackson, MS
3. "Social Inactivity Among Nursing Home Residents", Dr. Laura Carstensen, Indiana University, Bloomington, IN
4. "Conversational Skills Training for Socially Isolated, Impaired Residents of Nursing Homes", Dr. Marian

MacDonald, University of Massachusetts, Amherst, MA
5. "How to Apply Behavioral Technology to Groups of Elderly in Day Treatment Centers", Dr. Roger Patterson, Veteran's Administration-Outpatient Clinic, Daytona Beach, FL
6. "Behavioral Family Approaches to Alzheimer's Disease in Long Term Care", Dr. Nathan Linsk, University of Illinois at Chicago, Chicago, IL
7. "Environmental Manipulations to Modify Behavior of Elderly Psychiatric Persons", Dr. Richard Hussian, Terrell State Hospital, Terrel, TX
8. "Sign Language for the Aphasics", Dr. Patricia Wisocki, University of Massachusetts, Amherst, MA
9. "Psychoeducational Interventions for Distressed Caregivers", Dr. Larry Thompson, Veteran's Administration Medical Center, Palo Alto, CA
10. "Behavioral Treatment of Urinary Incontinence in Outpatients", Dr. Kathryn Burgio, Francis Scott Key Medical Center, Baltimore, MD
11. "Behavioral Treatment of Urinary Incotinence in Geriatric Long Term Care", Dr. Louis Burgio, National Institute on Aging, Baltimore, MD
12. "Behavioral Assessment and Treatment of Depression in Alzheimer's Disease", Dr. Linda Teri, University of Washington, Seattle, WA
13. "Altering the Consequences of Caregiving", Dr. Elsie Pinkston, Elderly Support Project, University of Chicago, Chicago, IL
14. "Methodological Issues in Evaluating Intervention with Caregivers of Dementia Patients", Dr. Steven Zarit, Penn State University, University Park, PA
15. "Issues in the Measurement of Caregiver Stress and Burden.", Dr. Gary Deimling, The Benjamin Rose Institute, Cleveland, OH
16. "Discussion of Selected Issues In Behavioral Research on Aging", by all members of the Symposium, with imput from the audience

PANELS/ROUNDTABLES

Chicago

Commons Community Association, March 1987, "Elderly and the Family." Earlie Washington

Regional

Indiana State Conference on Alzheimer's Disease & Related Disorders, May 1987, Merrillville,IN, Dr. Pinkston

National

The National Council on Aging, Annual Meeting, March 1987, Chicago, IL

1. Round Table, Spencer DeRoos
2. Round Table, Robin Goldberg-Glen
3. Round Table, Brenda McGadney
4. Round Table, Earlie Washington

PUBLICATIONS

Handouts

The National Council on Aging, Annual Meeting, March 1987, Chicago, IL, Handouts and Posters at the University of Chicago's Exhibition Booth

Articles

McGadney, B.F., Goldberg-Glen, R.S. Pinkston, E.M. (In press) Clinical issues for assessment and intervention with the Black elderly. In L.L. Carstensen & B.A. Edelstein (Eds.), Handbook of clinical gerontology. New York: Pergamon.

Pinkston, E.M., Howe, M.W., and Blackman, D.K. (1987). Behavior Management of urinary incontinence of the elderly. (To appear in the Journal of Social Service Research).

Green, G.R., Linsk, N.L., and Pinkston, E.M. (1986). The modification of verbal behavior of the impaired elderly. Journal of Applied Behavior Analysis, 19, 329-336.

Working Manuscripts

Pinkston, E.M., Linsk, N.L., and Young, R.N. Assessment of home-based behavioral treatment of the impaired elderly. (Invited article for Behavior Therapy).

Pinkston, E.M., (In progress). Family Intervention with the cognitively impaired elderly. In B.A. Thyer (Ed.), Behavioral family therapy. Beverly Hills: Sage. (Due Oct.1)

Planned Manuscripts

Pinkston, E.M. (Ed.) (In progress). Behavioral gerontology: Proceedings from the Charlotte Lewis Symposium.

Goldberg-Glen, R. and Pinkston, E.M. (In data analysis phase). Analysis of effectiveness of behavioral training of adult daycare staff.

Pinkston, E.M. and DeRoos, Y.S. (In data analysis phase). Skill development with adult daycare staff.

Manuals

Pinkston, E.M., Goldberg-Glen, R., DeRoos, Y. S., and Washington, E. M.(In progress partial manuscript). Behavioral methods in adult daycare: A staff training manual.

Books

Pinkston, E.M. and Young, R.N. (In progress). Home-based treatment of the impaired elderly.

IV. Policy/Program Implications and Recommendations

The multifaceted nature of this grant makes it difficult to determine a single set of policy implications related to its various outcomes. Since, however, the project objectives fall within the general rubric of training and support to family caregivers, some of the more salient implications of our results relate to issues about sustaining family caregiving and preventing early institutionalization of the elderly are outlined below.

- First, generally speaking, the fact that this study supports the successful implementation of a training methodology for adult day center caregivers of impaired elderly persons lends support to current AOA policy to continue to allocate representive proportions of its appropriations to training professional caregivers services to caregiving families.

> **Recommendation 1**: Grant support for research to develop and test training models and other inventions to ascertain what type of model best support caregiving families should be continued.

- There were at least five policy implications that can be drawn from the results of our efforts to develop and implement a behavioral management training program for staff working in an adult day care setting and family caregivers.

1) The behavioral model is an effective approach in training staff working with the elderly, and when staff correctly reinforce and cue positive behaviors, improvements in the elderly person's behavior are more likely to occur.

2) The recognition that caregivers who participated in the training sessions frequently used the sessions not only to learn how to effectively manage their older relative's behavior, but also to receive counseling, advise and information about formal services, suggest the need for training models to be flexible and incorporate in the training design ways to respond to individual family needs if the training is to be truely supportive to families.

3) The finding that problem behaviors of the elderly can be successfully modified by intervening with families and helping professionals responsible for the care and well-being of the elderly person suggest that policymakers and funding sources, when planning programs for the elderly, should seriously considered the needs of the caregivers, as well as the needs of the the primary client group, the elderly.

4) While the behavioral training model's effect on decreasing institutionalization of the elderly clients is inconclusive, based on caregivers' subjective evaluation of the training, such a training model can at least be a significant contributor to the well-being of the family participants during their involvement with the project.

Recommendation 2: Training of adult day care staff and other aging care personnel should be multi-disciplinary and include attention to the needs of the caregiver.

- Policy implications from our experience in providing training to adult day care centers and caregiving families include the following:

1) Though needs assessments may indicate a need for training among adult day care personnel, ongoing in-service training or on-the-job training are most effective when the center director and staff are involved in the planning and implementation of the training sessions themselves.

2) When planning to provide on-the-job training to adult day centers or similiar agencies using such a model as presented in this research, consideration must be given to the potential impact of changes in administration, staff, and clients on the desired outcomes.

3) When planning to provide an on-going training program for caregivers, consideration should be given to recruitment issues and other factors that prevent caregivers from participating such as time constraints, scheduling problems, and no one to leave elderly client with while caregiver attends training.

Recommendation 3: Researchers and aging service personnel should develop collaborative relationships to facilitate strategic planning and problem solving as to ensure that the research project achieve the intended objectives.

Recommendation 4: Formal care providers working with caregiving families should coordinate home-based and agency-based approaches to training, information dissemination and service utilization in order to alleviate caregiver stress and prevent family breakdown and unnecessary institutionalization.

Recommendation 5: The absence of behaviorally trained spanish speaking gerontology staff should be corrected by special training programs. Therefore money should be set aside for such programs.

V. Executive Summary

The primary aims of this research project were to prevent early institutionalization of impaired elderly persons and to improve their quality of life by training adult day care staff and families of the elderly to use behavioral procedures in the provision of care. The implementation of behavioral procedures in day care centers involved developing staff and family training packages designed to teach informal and formal care providers specific skills to help alleviate the behavioral and environmental problems associated with old age and chronic illness.

The beneficiaries of this research were adult day care staff, family caregivers and elderly persons over age 60 with behavioral deficits (physical and mental impairments) associated with old age and chronic illness, and who were currently participating in adult day care programs in Metropolitan Chicago. The research design use a single subject experimental design to evaluate behavioral learning by staff and improved behavior by the elderly clients. Pre and post tests of the elderly clients and family caregivers, direct observations of behavior, participant evaluations, and staff evaluations were the primary data sources. Demographic information was obtained using the OARS, a multidimensional assessment tool.

The training and research were conducted in five adult day care centers with 30 staff and 15 family members during the two year grant period. The program underwent major revisions as the experimenters developed a more realistic sense of the day centers time table and was conducted on site following a brief instruction period while staff were working with elderly clients. Staff were taught specific behavioral techniques in ten on-site training sessions, followed by five consultation sessions in which staff implemented and evaluated specific behavioral interventions for individual client problems. More specifically, staff were taught to identify reinforcing consequences, to use reinforcement, successfully analyze tasks, identify and use cues (prompts), implement contracts, develop client skills, apply procedures, and design and conduct group activities with clients. Following staff training, family caregivers were recruited for four group sessions design to teach rudimentary behavioral techniques.

The results of the research project, clearly demonstrate that staff were able to use behavioral techniques which resulted in behavioral improvement in selected behaviors of clients. These findings, however, suggest that the caregiver's involvement in training and adult day care is difficult to obtain and that although family training in previous home-based research was useful, cooperation in a four session group training program in the day center was impossible to achieve on a large scale. Further, this research contributed to our understanding of the difficulties involved in coordinating family (informal) and day center (formal) resources in a consistent way to enhance the social functioning of the elderly. Results of behavioral training of staff benefited the elderly clients by reducing confusion, increasing positive activities, and increasing client opportunities to receive positive consequences in the day centers..

1 Objectives

The primary aims of this research project were to prevent early institutionalization of impaired elderly persons and to improve their quality of life by training adult day care staff and families of the elderly to use behavioral procedures in the provision of care. The first objective of the research was to develop and evaluate a training program for adult day care staff in behavioral management techniques to enhance the social functioning of impaired elderly clients in adult day care. The second objective was to generalize behavioral techniques to train family caregivers of impaired elderly clients in adult day care to manage behavior problems.

The research questions were designed to examine the generality of previously successful behavior modification procedures used with seriously impaired older persons in nursing homes to day care (Pinkston & Linsk, 1984). More specifically, the research addressed the following questions:

1) How can informal supports (family based care) and formal supports (adult day care) supplement each other to assist older persons with severe behavioral problems resulting from Alzheimer's and other dementias?

2) Will this combination encourage continued structured at-home care as an alternative to long-term institutional care?

3) What are the cost implications for families and providers of substituting home-and day-center-based services for residential care?

4) Can behavioral change in either settings be transferred to the other setting? Can extension of educational procedures from the behavioral literature be effective across multiple settings?

5) Are procedures developed and evaluated in research projects to teach families to treat behavioral problems at home appropriate for day care staff?

6) What is the result of using these procedures on family caregiving patterns, use of other services, and long-term care placement?

7) What are effective uses of reinforcement and stimulus control techniques in helping to alleviate behavior problems of older persons in family and service settings?

These questions are particularly important to service providers, practitioners, families, and gerontologists, due to the limited resources and increased awareness of limitations of long-term care arrangements and an increasing population of older persons with intellectual and behavioral difficulties. More specific programs are needed to help families deal with problematic behavioral patterns and to integrate efforts by families and formal service providers.

Previous research has indicated the usefulness of behavior modification both to older persons and families of younger persons with behavioral difficulties and their families (for a review see Reidel, 1981). The potential for applying behavioral procedures as an independent intervention to problems of older persons has seldom been systematically evaluated. Initial studies carried out by the authors (Pinkston & Linsk, 1984a; 1984b; Green, Linsk & Pinkston, 1986) developed and tested a short term intervention model that has been helpful in improving specific behavior problems, forestalling or avoiding institutional placement, and improving family caregiving.

Adult day care has emerged as a viable alternative to institutional care. Community based adult day care centers provide clients with needed services and with opportunities to be with with others with similar social and recreational interests. To be effective, adult day care centers need caregiving staff skilled in providing services and in facilitating clients' involvement in desirable, meaningful activities.

The number of adult day care centers in the United States increased from 15 in 1974 to 1500 in 1985. This increase has highlited the need to ensure that staff at such centers are trained to give effective client care. Conscious of both costs and the need for good client care, agency administrators are likely to see as most desirable those training programs that are cheap, take as little time as possible, are minimally disruptive of agency routine and, are effective in training staff in needed skills.

With that in mind the Elderly Support Project (ESP) staff designed a training program that would: a) teach agency staff the techniques necessary to be effect caregivers; b) minimize the amount of staff work time and other agency resources needed to conduct the training; and c) maximize incorporating training into staffs' and agency ongoing activities.

The theory used as the basis for this work was primarily operant with some observational techniques drawn from social learning theory (Pinkston & Linsk, 1984). Basic to operant theory is the "law of effect," which refers to the likelihood of a recurrence of an individual's behavior under similar circumstances. The likelihood of a recurrence of a behavior increases or decreases depending on the consequences of that individual's actions. Those behaviors that are associated with desirable consequences are strengthened (Pinkston, et al., 1982; Rodd, Porterfield, & Anderson, 1979).

The principles of operant theory address the relationship between a behavior and the environmental events that are presumed to control that behavior. Although operant theory is generally associated with the effects of the consequences of behavior, antecedent events are also recognized as being related to the occurrence of behaiver. Lindsey (1964) specifies four stages of the "functional analysis of behavior": the antecedent stimulus or stimulus setting in which the behavior occurs; the actual behavior of interest; the contingencies of reinforcement; and the environmental event that follows the behavior.

The model in this research used only the reinforcing consequences of behavior and none of the punishing consequences for several reasons. First, it was decided that the training would focus on staff and client task performance rather than on problems. The would focus attention on client and staff skills and accomplishments and away from staff and client deficits. Since the intention was to enhance skills and task accomplishments, that is, to increase desirable behavior and outcomes, reinforcing consequences had to be used.

An additional reason for using only reinforcing consequences in the training program centers was to respect the autonomy of the staff and clients. It did not seem proper to use punishment (negative consequences) simly because one did not perform as had been wished. Therefore, punishment was excluded from the training. There are more practical reasons for not using punishment, of course. It leads to avoidance behavior and resentment and one may be modelling the very techniques one wishes to avoid teaching.

The training literature indicates that effective behavioral staff training produces caregivers who have the knowledge and skill to be effective caregivers (Hussian, 1981; Kazdin, 1980). Institutional staff training methods have included the traditional approach of employing verbal, visual or written techniques such as lectures, discussions, and the use of reading materials, films and slides (Hersen & Bellack, 1978; Kazdin, 1980). These methods are essentially informative and are useful for increasing knowledge about general behavioral principles, and also appear useful for learning about intervention techniques and procedures (Cuff, 1977; Delametter, Conners, & Wells, 1984; Gardner, 1972; Schinke & Wong, 1977).

Studies show that these methods have little or no effect in developing applied skills (Bernstein, 1984; Delametter, et al., 1984). Staff training methods which have been found effective for teaching behavior change skills including modelling, in which the desired behavior is demonstrated and is observed by the trainee (Gladstone & Spencer, 1977), feedback, the process of providing someone with information about that persons performance to guide subsequent performance (Parsonson, Baer, & Baer, 1974), reinforcement, a procedure that strengthens the tendency of a response's recurrence (Delametter, et al., 1984), and various combinations of these methods.

This model was designed to be implemented on-site to avoid the problem of generalization (transfer of learning) from one setting to another. It also taught staff specific skills and evaluated them before going on to the development of interventions with elderly clients (For an examination of generalization issues see Chapter 9 in Pinkston, et al., 1984).

The Elderly Support staff of the University of Chicago's School of Social Service Administration conducted the research in five adult day centers in Metropolitan Chicago during the two year funding period. Initial start-up arrangements were made during an orientation meeting with the directors of each adult day center. A package outlining the proposed project was presented to all of day care centers who expressed an interest in staff training. Afterwhich a meeting was arranged to discuss centers' involvement in the research project. The administration of five centers agreed to participate in the behavioral management training program.

All the centers were private non-profit organizations and three centers were primarily funded by the State of Illinois. In all cases both clients and staff were representative, both socio-economically and ethnically of the communities serviced by the adult day centers. All centers represent a social model where services are designed to facilitate social interaction among the participates. Services provided by the centers usually include nutrition, education, daily physical exercise, counseling, and family respite.

In each case both participants and staff were representative of their communities, both socio-economically and ethnically. All the sites provided such generic services as transportation, social/recreation, education, continuous supervision, nutrition (lunch and snacks), information and referral and personal

care. Each setting represents a micro-community of cultural richness. Below is a brief description of each center

The clients in this research were restricted to those with a caregiver to allow generality testing of the behavioral parent training research. Specific referral criteria were established for this project and distributed to day center staff. The initial criteria for selection were (a) clients over 60 years of age; (b) diagnoses include severe psychological problems and/or brain dysfunction including chronic and acute brain syndromes, reactive mental disorders, depressions that would otherwise prevent community functioning, schizophrenia, senile psychosis, paraphrenia, arteriosclerotic brain disease, acute confusional states or physical impairments such as cardiovascular accidents, arthritis, fractures, or spinal cord injuries; (c) the client function at excessive disability, that is, functional disability is greater than warranted by their health status (Kahn, 1965); (d) caregivers include family or others to participate in behavioral change efforts; (e) behavioral excesses or deficits in rates of appropriate or inappropriate behavior, family interaction dysfunction, interpersonal problems, communication difficulties, social isolation, or inability to engage in activities of daily living; and (f) low rates of interaction with community activities or services.

Regarding the staff selection criteria, all staff members who worked full time at the day centers and or who had direct contact with ADC participants were considered appropriate for the training program. While participation in the training program was encouraged, all partcipation was voluntary.

The research design for this program included single subject experimental designs to evaluate and compare changes of clients within adult day centers and between clients of different day centers. Pre and post test surveys assessed related changes and the responses of the elderly family members and staff. This design also allowed the program to assess the effectiveness of staff using specific behavioral procedures such as reinforcement and stimulus cueing (Pinkston, et al., 1982; Pinkston & Linsk, 1984) as well and their effectiveness with specific problems. Below is a brief description of the variety of measurement tools used to collect data.

Direct observations of older of elderly client's behavior and interaction between staff and clients several as data sources for the study. Two kinds of observational data were included: (1) continuous time sampling procedures to assess baseline and post-intervention interactions between staff, family, and elder persons; and (2) family and staff recorded instruments which monitored the frequency of specific targetted behaviors. A family behavioral record is included in the Appendix as a general instrument to record daily behavior frequencies. At the end of the ten training sessions a structured observation system was used to evaluate the staffs' skills at implementing the operant procedures. This assessment tool consisted of nine structured activities, each oriented towards a specific set of the operant techniques used to deal with the elderly.

The implementaion of a structured observation system was used by the trainer to evaluate the staffs' use of the behavioral procedures in the natural environment. Standerized situations consisted of structured tasks oriented toward the operant techniques taught to the staff. During this phase of training the staff member was asked to follow instructions for a brief structured activity. The trainer at the same time used an observtion system to record the staffs' response. Structured evaluations allowed the trainer to determine whether or not the staff developed the skills necessary for designing and implementing a behavior intervention.

Other data sources included pre and post-test assessment survey of staff and family caregivers. A questionnaire used in previous research, the OARS Multi-Dimensional Assessment Instrument (1978) was administred to caregivers at two points in time, at the beginning of training program and at the end. The appropriate demographic data were recorded to allow comparison between cases. Specifically, an Older Persons Pretest Questionnaire, a Support Person Pretest Questionnaire, and Staff Agent Pretest Questionnaire were administered. (See Appendix B for Instruments).

Behavioral management tools provided additional data, including a visit checklist, a telephone checklist, and activity logs to monitor the time spent in various activities and how specific techniques and procedures were implemented (See Appendix C for Behavioral Assessment Forms).

4. The Staff Intervention (Training) Model

The basic model tested was a short term behavioral intervention model. Training, evaluation, and assessment occurred within 10 on-the-job sessions, and 5 consultation sessions which involved designing and imple-menting an intervention with targeted clients. The intervention model included several steps: 1) Group instruction sessions which focused on teaching the staff how to use operant procedures including: principles of reinforcement, task analysis of client behavior, cueing, activities programming, behavioral contracting, group skills, differential reinforcement of incompatible behaviors, and skill development; 2) on-site training sessions which involved an unstructured observation of the staff in the adult day setting and provision of corrective feedback and reinforcement; 3) structured observation system used to evaluate the staffs' skills at implementing the operant procedures; 4) development, implementation and single case evaluations of behavioral interventions for targeted ADC participants; and 5) development of maintenance procedures. Project workers used instructions, feedback, and modeling as well as instructional materials to teach day care center staff to implement behavioral procedure. Each of these variables were used to effect changes in behavior on the part of staff and changes in the day setting to promote more positive client behavior.

The family training model provided instructions designed to assist the caregivers in learning how to : (1) operationally define behavioral deficits and excesses, (2) monitor behavior using observation and data collection techniques, (3) graph data, and design, implement, and evaluate a behavioral intervention. The training also provided an opportunity for the caregivers to learn how to monitor, evaluate, and increase their own reinforcing activties.

The training model consisted of 4 1-1/2 hour group training sessions. After the complete implementation of the Behavior Management Training Model with staff at the day care centers, family training was initiated at two of the five centers. All family caregivers in these centers were offered the opportunity to participate through the day center administration. A total of 15 family members of the impaired elderly day care participatants began the training sessions.

The behavioral assessment observations indicated that staff improved on all trained skills with only one staff member failing to improve on the Behavioral Principles Inventory. In general the model produced both cognitive and behavioral improvement on staff scores.

The family aspect of training was unsuccessful. Pinkston's previous research using a home-based rather than day care based intervention and showed a high degree of skill development for family caregivers plus satisfaction. Once they were asked to leave their homes the caregivers failed to participate in the completion of the training task and most caregivers opted not to participate.

Implications are that this model is useful for staff training and that a home based intervention is more likely to be helpful for the family caregiver. Day care center should consider the possibility of providing a home-based service similar to the one used for staff in this study.

Figure Captions

Figure 1. Percentage of Reinforcement Task Performed Correctly

Figure 2. Percentage Increase Between Pretest/Posttest of Reinforcement Task Performed

Figure 3. Percentage of Task Analysis Performed Correctly by Staff

Figure 4. Percent Increase Between Pretest/Posttest of Task Analysis Performed Correctly by Staff

Figure 5. Percentage of Cueing Task Performed Correctly by Staff

Figure 6. Percent Increase Between Pretest/Posttest of Cueing Task Performed Correctly By Staff

Figure 7. Percentage of Behavioral Contracting Performed Correctly by Staff

Figure 8. Percentage Increase Between Pretest/Posttest of behavioral Contracting Performed Correctly by Staff

Figure 9. Average Percentage Increase Between Pretest/Posttest of Assessment Tasks Performed Correctly by Center

Figure 10. Data Summary 404

Figure 11. Data Summary 1011

Figure 12. Percentage Improved on HPKI by Staff

Figure 13. Percentage of Correct Answers of HPKI by Staff

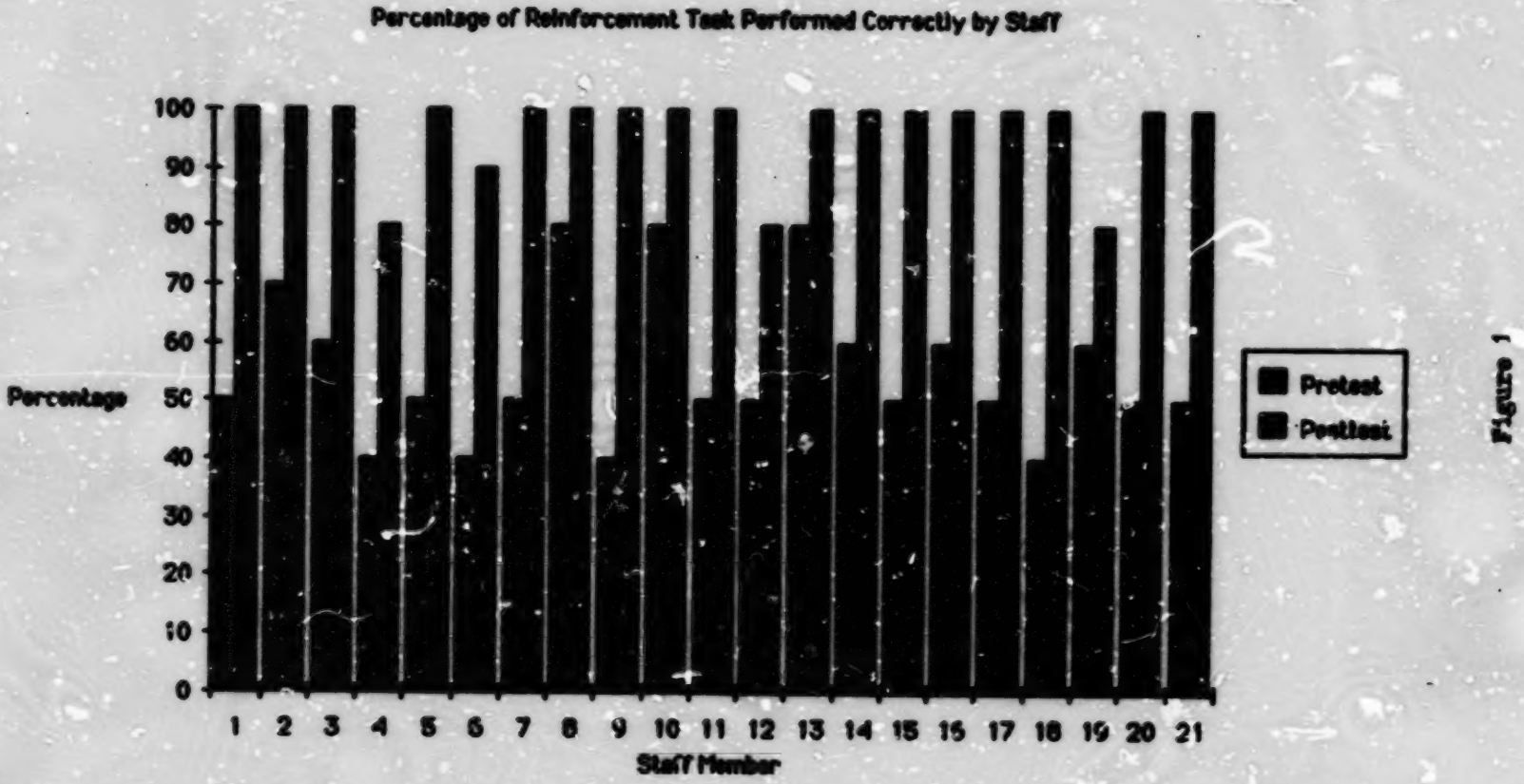

Figure 1

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Percent Increase Between Pretest/Posttest of Reinforcement
Task Performed Correctly by Staff

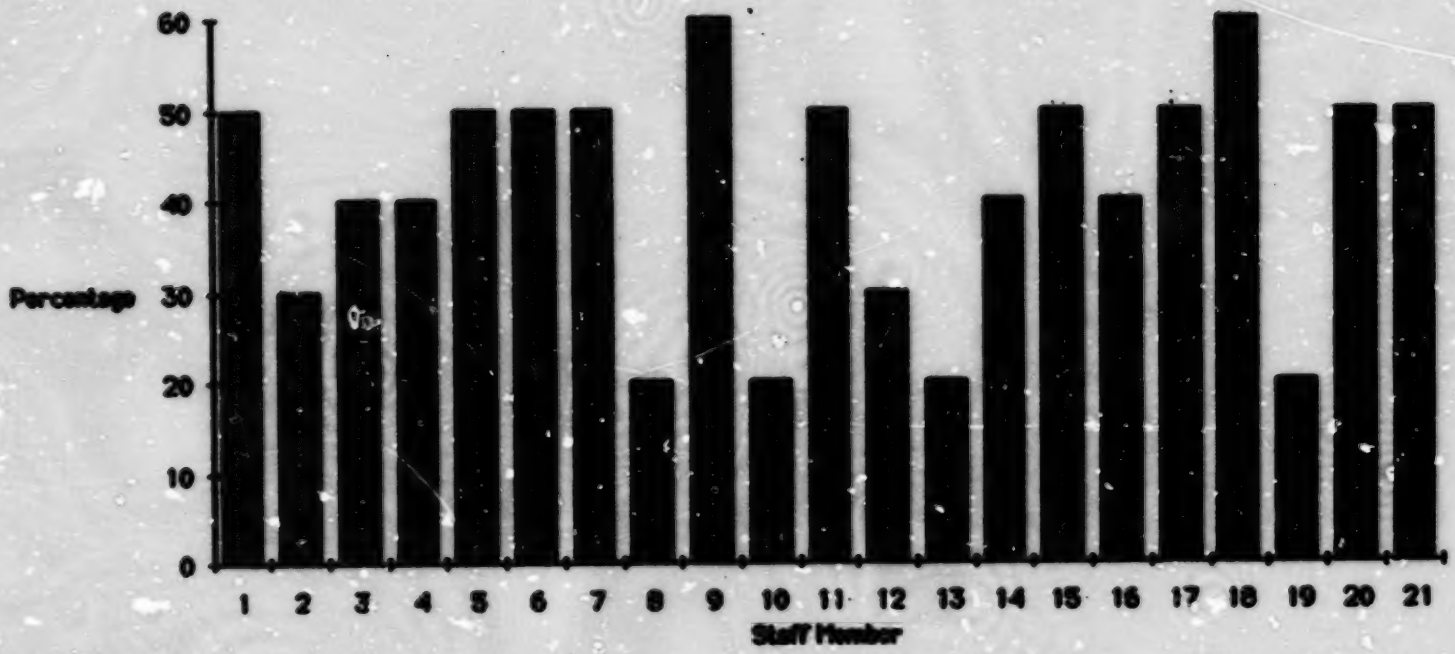

Figure 2

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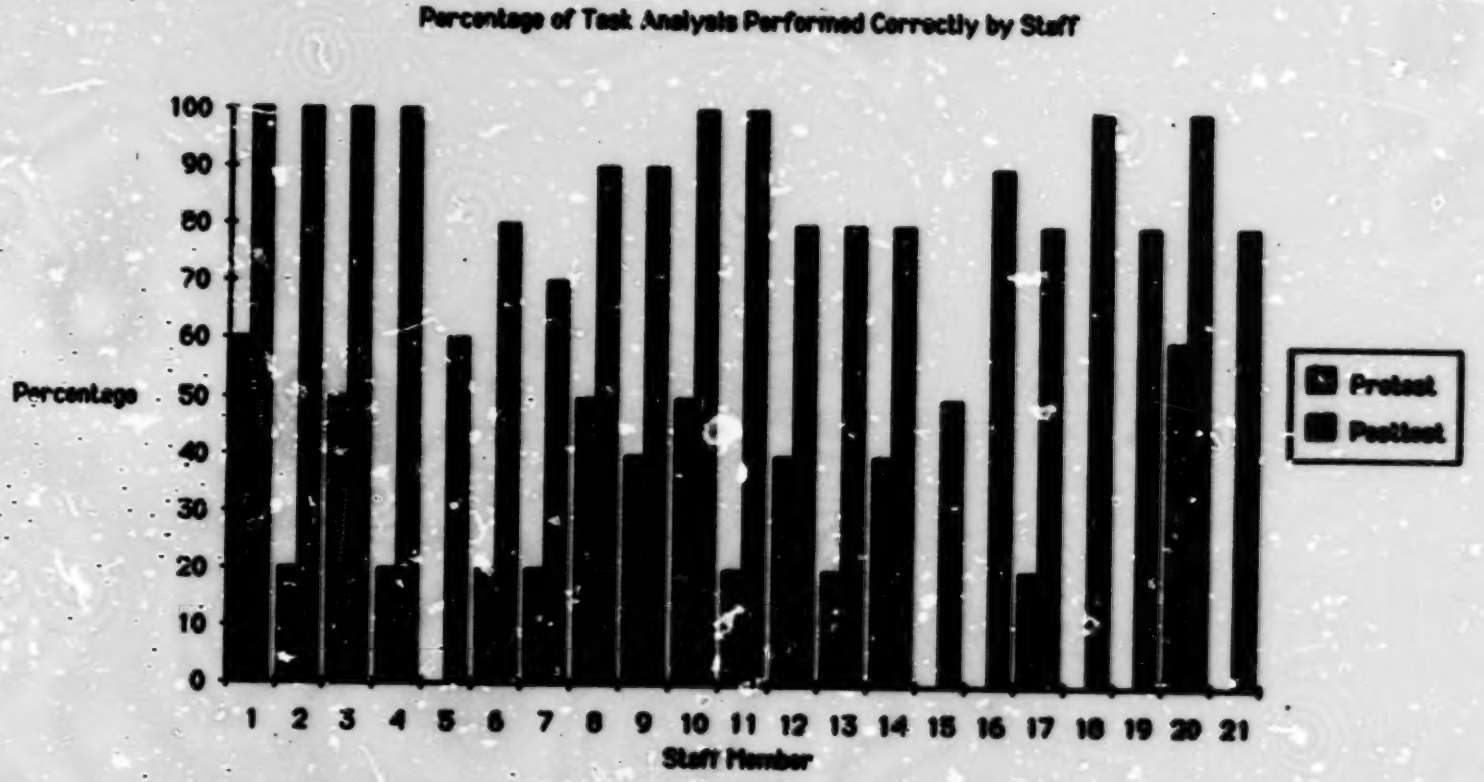

Figure 3

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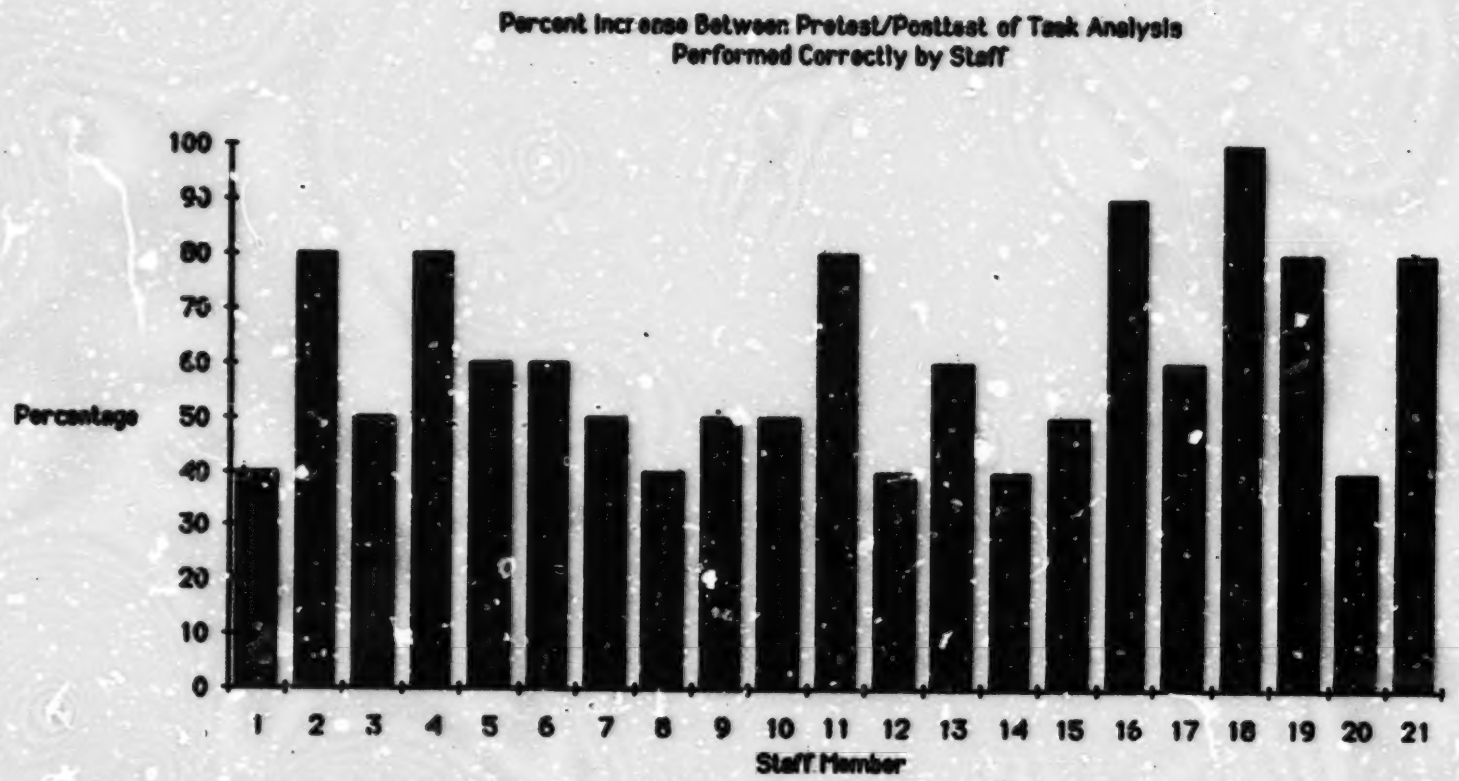

Figure 4 cont'd

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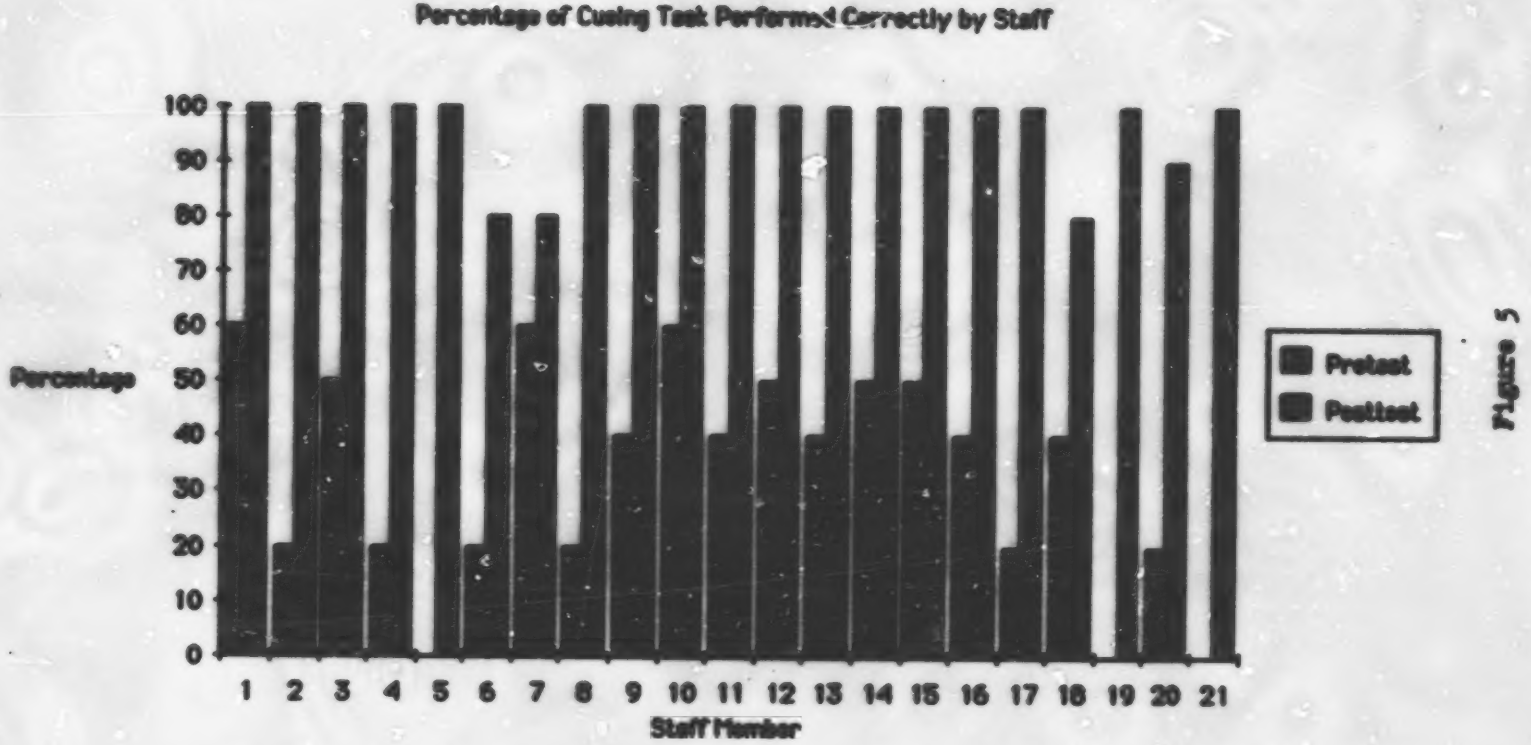

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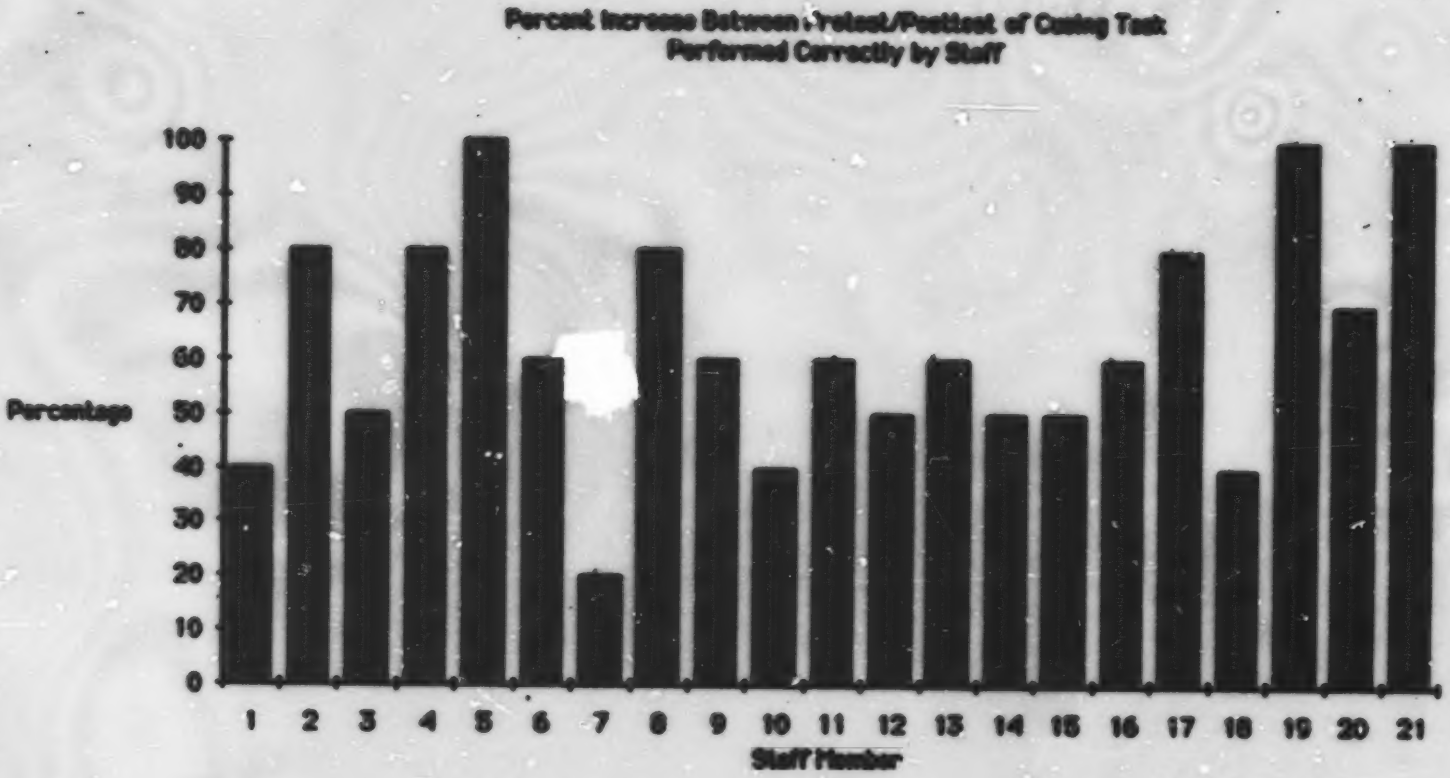

Figure 6

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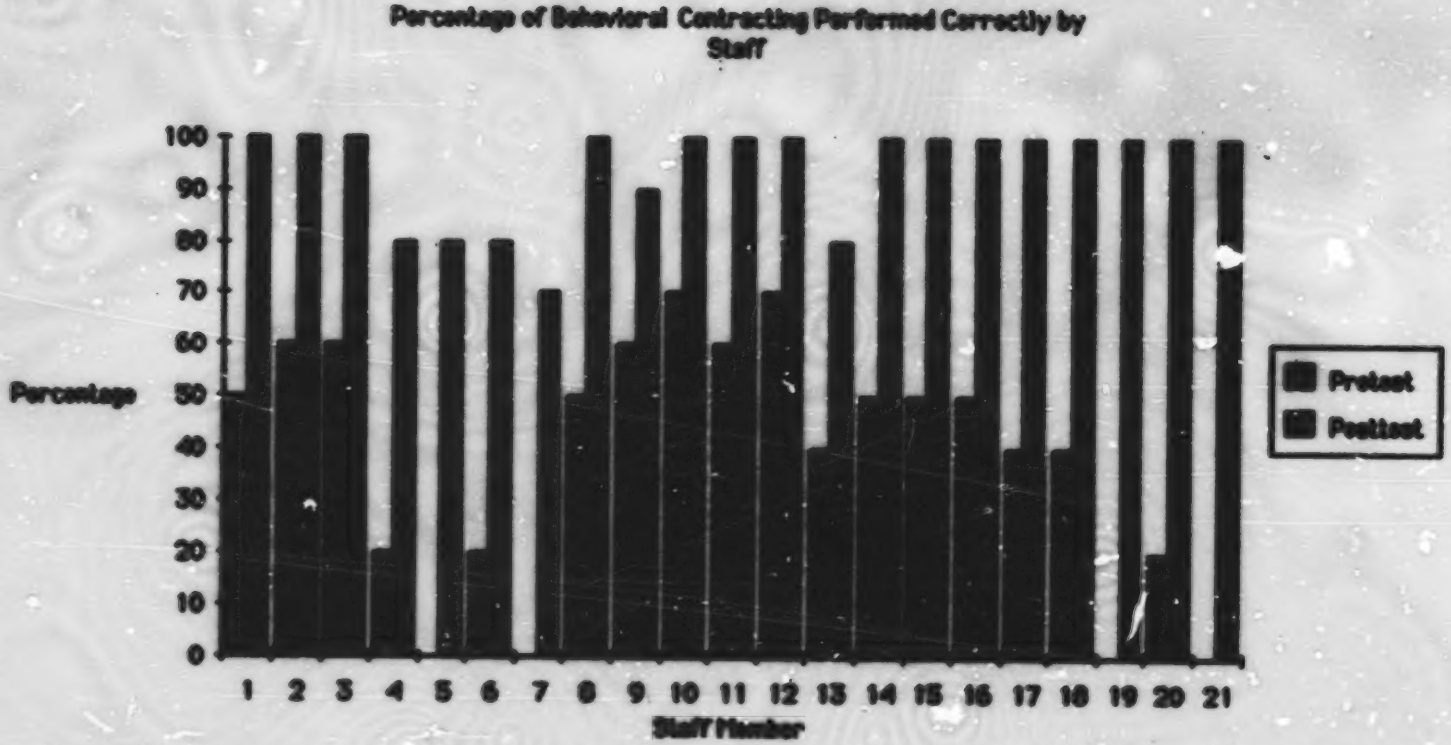

Figure 7

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Percent Increase Between Pretest/Posttest of Behavioral Contracting Performed Correctly by Staff

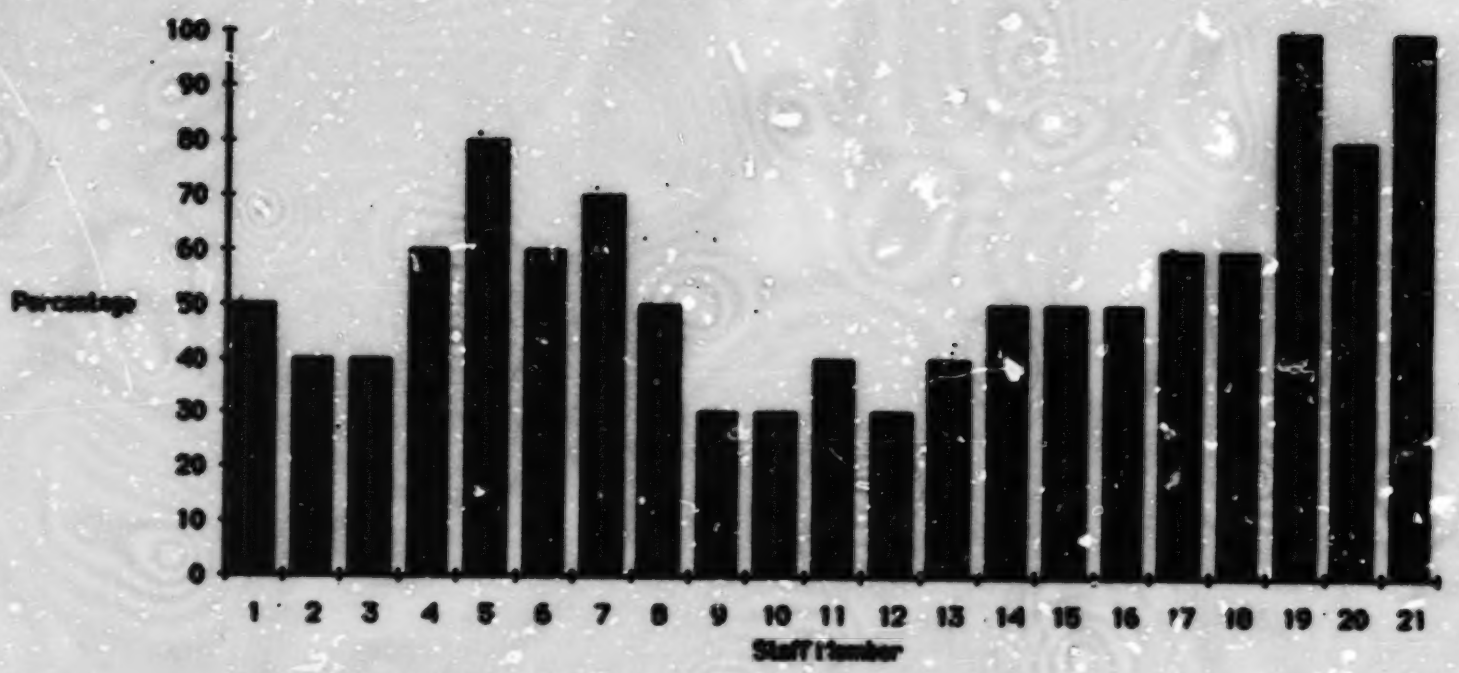

Figure 8

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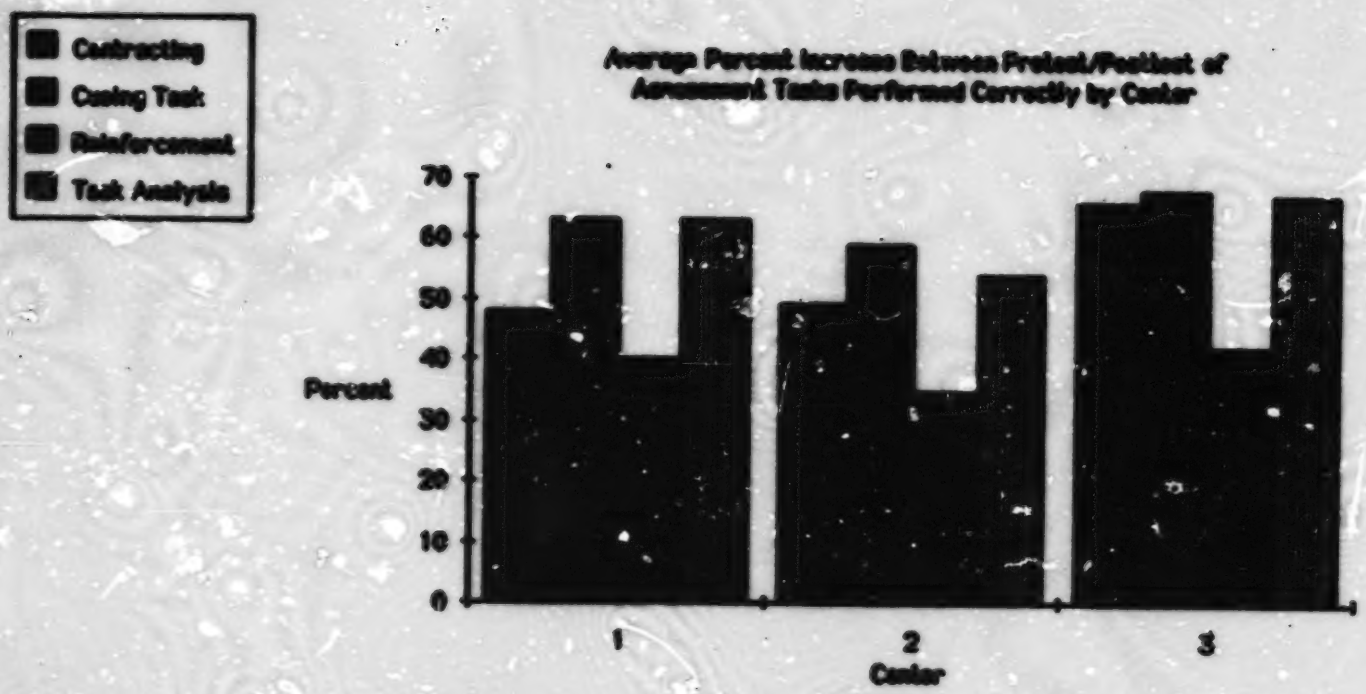

Figure 9

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Figure 9a

Baseline Data

Morning Activities

Date	Type of activity	Code 1=did participate 0=did not participation	Total Time participated
5/11	Current Events	0	0
5/12	Exercise	0	2 minutes
5/13	Current Events	0	0
5/14	Exercise	0	0
5/15	Current Events	0	0

Afternoon Activities

Date	Type of activity	Code 1=did participate 0=did not participate	Total Time participated
5/11	Exercise	0	0
5/12	Bingo	1	15minutes
5/13	Exercise	0	0
5/14	Bingo	1	10minutes
5/15	Exercise	0	0

Intervention

Morning Activities

Date	Type of activity	Code 1=did participate 0=did not participation	Total Time participated
5/25	Current Events	1	5minutes
5/26	Exercise	1	15 minutes
5/27	Current Events	1	5minutes
5/28	Exercise	1	15minutes
5/29	Current Events	1	5minutes

101

Figure 10

Baseline Data

Positive and Negative Statements about Male Client

Date	Positive Statements	Negative Statements
3/2	0	4
3/4	0	5
3/6	0	4

Positive and Negative Statements about Clients in General

Date	Positive Statements	Negative Statements
3/2	0	2
3/4	0	1
3/6	0	3

Intervention Data

Positive and Negative Statements about Male Client

Date	Positive Statements	Negative Statements
3/23	3	0
3/25	4	0
3/27	5	0

Positive and Negative Statements about Clients in General

Date	Positive Statements	Negative Statements
3/23	1	0
3/25	3	1
3/27	2	0

Afternoon Activities

Date	Type of activity	Code 1=did participate 0=did not participate	Total Time participated
5/25	Baking cookies	1	15minutes
5/25	Bingo	1	30minutes
5/27	Exercise	1	10minutes
5/28	Bingo	1	15minutes
5/29	Exercise	1	5minutes

A List of Problems and Behavioral Interventions Used in Single-Case Designs at Two Adult Day Centers

Presenting Problem	Behavior to be Increased	Intervention
Client talks out in class inappropriately and distracts others who are listening to the instructor	When participating in class, client will raise his hand to be recognized. Once he has been recognized, he will talk about the topic of dicussion.	Reinforcement Cueing Differential Reinforcement
Excessive complaining	Increase positive statements	Differential Reinforcement
Lack of participation in activities	The client will participate in at least one group activity daily	Cueing Reinforcement Contracting
Client forgets to take off hat when he enters the center	The client will take off his hat and coat when he walks through the door of the center and hang them on the coat rack	Verbal Cueing Reinforcement
Wandering during rest period	The client is to engage in activities that will occupy the her time during rest period. Staff will change the furniture, in order to re-route the client so that others will not be distrubed when she walks.	Environmental Prompts Reinforcement
This client is the last client to leave the center in the afternoons. At the time the first client leaves the center, the client makes repeated requests to go home.	The client should engage in interesting activities during this time period	Cueing Reinforcement
Client smokes in unauthorized areas	Client will smoke in designated smoking areas.	Verbal Cueing Reinforcement

Figure 11

Percent Increase Between Pretest/Postest of Correct Answers
on BPKI by Staff

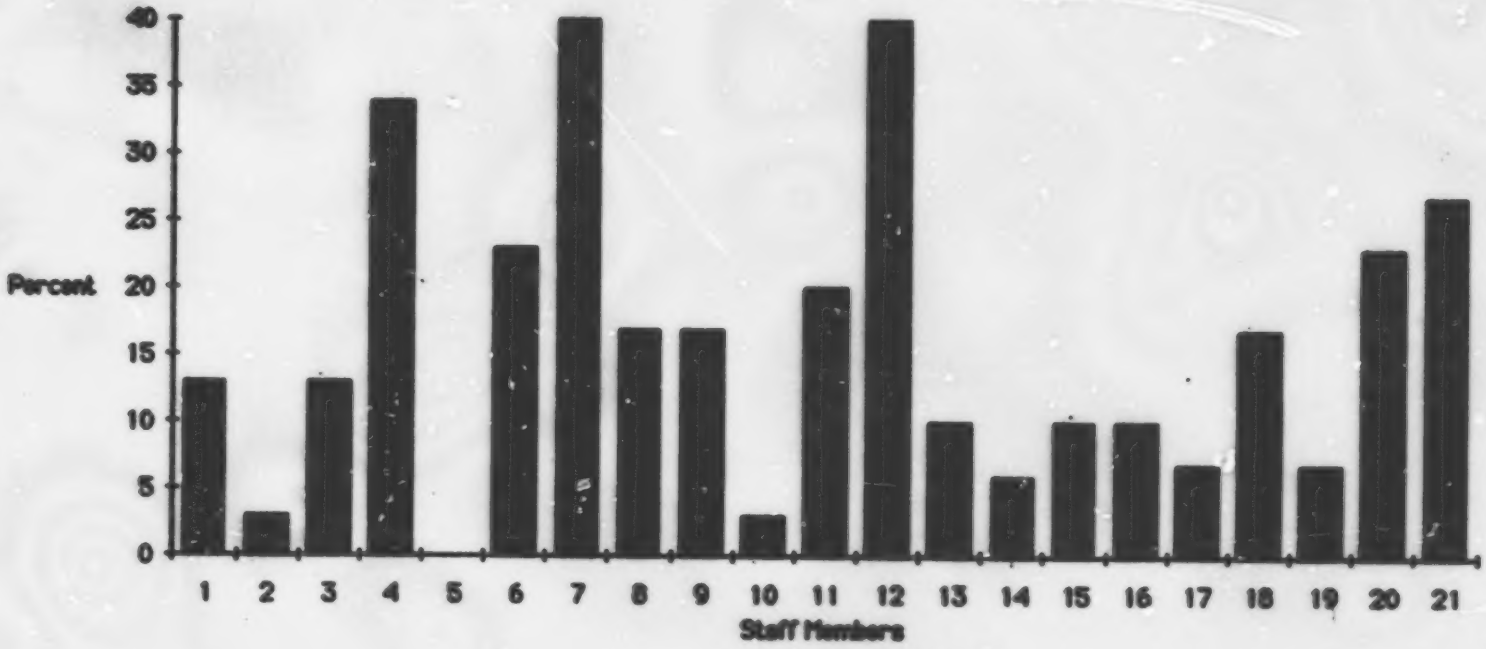

Figure 12

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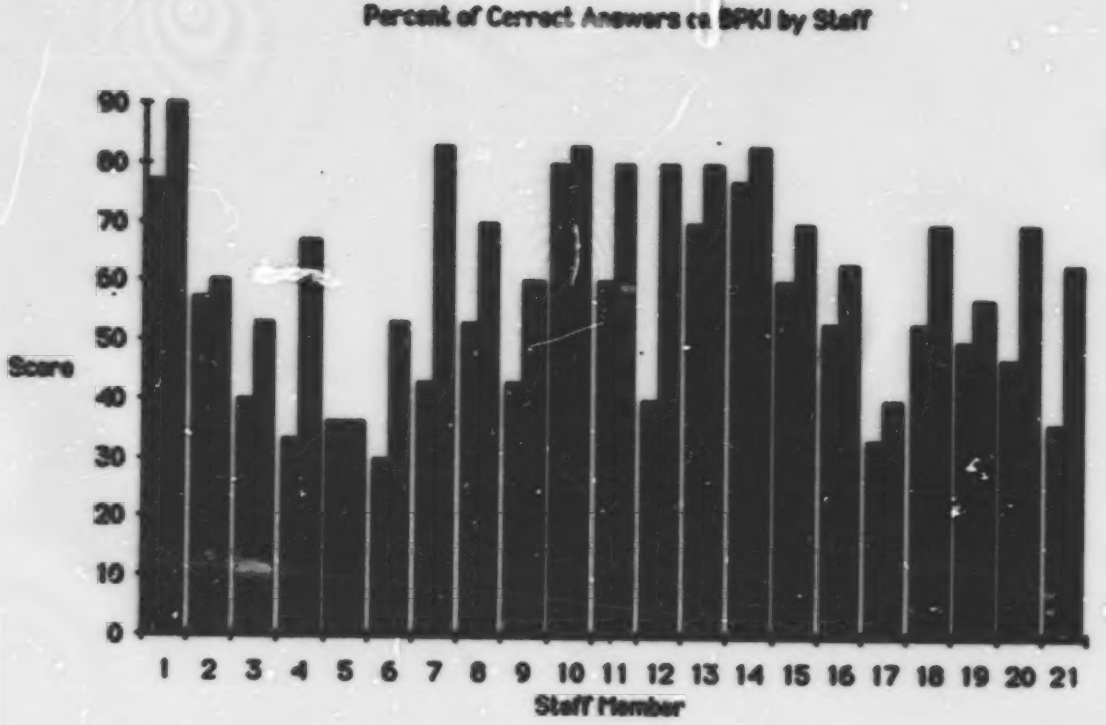

Figure 13

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APPENDICES

A. Recruitment of Clients, Families, and Staff--Sample Letters and Consent Forms

B. Staff Training--Assessment 1 and 2
   Behavioral Knowledge Inventory and Index of Organizational Reaction
   Skills Assessment Forms

C. Staff Training--Sessions 1-10
   - Session 1: Reinforcement Survey
   - Session 2: Reinforcement Task
   - Session 3: Task Analysis
   - Session 4: Cueing
   - Session 5: Activity Programming
   - Session 6: Contracting with Clients
   - Session 7: Group Skills Training
   - Session 8: Reinforcement of Incompatible Behavior
   - Session 9: Skill Recovery and Development Program
   - Session 10: Choosing an Intervention

D. Staff Training--Individual Consultation
   Sessions 11-15
   Certificate of Completion

E. Family Training
   Sessions 1-4

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APPENDIX A

Recruitment of Clients, Families and Staff

Sample Letters
Consent Forms

March 2, 1987

Dear _____

This letter comes as a follow-up to the letter you received in November, 1986 requesting your participation in the Elderly Support Project's day care research. The staff at Bethel New Life Adult ADC are currently participating in a training program sponsored by the Elderly Support Project. The training sessions are designed to teach staff specific behavioral procedures which will increase the elderly participant's social behavior, activity level, and wandering. Additionally, the staff will be trained to work with family members who are experiencing difficulties with their older relatives at home. Upon completion of the staff training, family members will also have the opportunity to participate in similar training sessions.

As I mentioned in the November letter, we at Bethel New Life are committed to providing training opportunities for our staff and family members. This training program appears to be particularly important because of its potential to strengthen and enhance our existing day care services and improve the skill levels of both staff and family members.

Therefore, I am asking you to please support this project by agreeing to complete two tasks. First, we need for you to sign and return the enclosed consent form. Second, we need you to participate in a structured interview with a staff member of the Elderly Support Project. All information is confidential and will be used to develop a data assessment profile on participants at Bethel ADC. Ms. Washington, project director, or Cynthia Steinhauser, interviewer, will contact you by phone, beginning March 7, 1987, to schedule an appointment for the interview. If you do not wish to be contacted, please notify me by March 6, 1987. Otherwise, I will assume that you have agreed to participate in this worthwhile project.

Again, we appreciate your support of this training project. If you have questions or need additional information, feel free to contact Ms. Washington at (312) 962-1250.

Respectfully,

Ms. Mary McAtee
Coordinator, Bethel New Life ADC

0052

September 17, 1987

Dear Family Members:

RE: Workshops for Family Members of ADC Participants at Southwest

This letter comes as a reminder that the first family workshops for participants at Southwest ADC will be held Tuesday, September 22, 1987 and Saturday, September 26, 1987. On Tuesday, the workshop is scheduled from 7:00p.m. to 8:30p.m. and on Saturday from 10:00a.m. to 11:30a.m. both at Southwest ADC. Several family members have selected the specific time frame they wish to attend. However, other interested family members who have not registered for a particular time, may select the time frame that is appropriate for them.

Family members who are interested in participating in these workshops, are expected to attend a total of four workshops, held once in September, twice in October and once in November. The workshops will focus on methods of supporting an older impaired individual in the home environment. The sessions will focus on specific needs of the family member and client, such as participating in activities, improving his or her social, physical or self care behavior, and managing problem behaviors. Overall, the workshops are designed to increase the client's involvement in the adult day care and in the home environments.

As mentioned, this training is being offered by the Elderly Support Project of the School of Social Service Administration, The University of Chicago. Also, these workshops are free to all family members of participants at Southwest ADC.

I enjoyed meeting with you on August 18, 1987 at the planning meeting and look forward to your participation in these workshops. If you have questions, please feel free to contact me at 702-1250 or Jean Kyrouac at Southwest ADC.

Respectfully yours,

Earlie M. Washington, MSW
Project Director
Elderly Support Project

0053

The Elderly Support Project
The School of Social Service Administration
The University of Chicago
969 E. 60th Street
Chicago, IL 60637

October 3, 1986

TO: Ms. Wanda Lewis, Program Director
Bethel New Life ADC

FR: Earlie Washington, Program Director
Elderly Support Project

RE: ADC Staff Training

The Bethel New Life ADC has agreed to participate in a training program being offered by the Elderly Support Project from the School of Social Service Administration, The University of Chicago. This program is designed to provide staff training to ADC staff and family training to caregivers and/or family members of elderly participants at Adult Day Care Centers in the Chicago area.

Staff training is scheduled to start in late October and will last for 10 weeks. Subsequent to the training, a five week consultation period is planned where the staff will have an opportunity to demonstrate the skills they have acquired. I will serve as the trainer for the entire 15 week period and will conduct two training sessions per week for staff at your center.

Staff will be trained to use specific procedures which will help to improve and increase the elderly participant's social behavior, activity levels, and alertness. Also, these procedures will be used to decrease problem behaviors such as abusive verbal behavior, improper toileting, and wandering. Additionally, the staff will be trained to work with family member who are experiencing difficulties with their older relatives at home. Each staff member who successfully completes the training will receive a certificate of completion from the Elderly Support Program, University of Chicago.

For additional information, I have attached a copy of the outline of the training activities and copies of the training content and assignments for the 10 week training period. Please note that a pre-assessment is scheduled prior to the training and a post-assessment after the 10 weeks of training. If you have questions regarding the training, please contact me at 962-1250. I look forward to working with the staff at Bethel and trust that we will have a very successful and productive training program.

Enclosure:

Elderly Support Project
The University of Chicago
969 East Sixieth Street
Chicago, IL 60637

Consent by Client

I,_____agree to participate in the Elderly Support Project. This opportunity has been offered to me through the University of Chicago, School of Social Service Administration. The project has been explained to me and I have been allowed to ask questions. I understand that I can withdraw my consent to participate at any time. I further understand that results of the program may be presented orally and published but that my identity will be held confidential. I also give permission for the Leyden Adult Day Center to allow the Elderly Support Project to have access to my records also with the understanding that my identity will be held confidential should any of the information be included in their project reports.

_____
Signature

Witness_____

Date_____

Time_____

0056

Elsie M. Pinkston, Ph.D., Principle Investigator
Rosemary Nelson Young, M.A., C.S.W., Program Director

Elderly Support Project
The University of Chicago
969 East Sixtieth Street
Chicago, IL 60637

Consent by Guardian or Family Member

I,_____agree for my relative,

_____ to participate in the Elderly Support Project. This opportunity has been offered through the University of Chicago, School of Social Service Administration. The project has been explained to me and I have been allowed to ask questions. I understand that I can withdraw my consent to participate at any time. I further understand that results of the program may be presented orally and published but that my identity will be held confidential. I also give permission for the Leyden Adult Day Center to allow the Elderly Support Project to have access to his/ her records, also with the understanding that his or her identity will be held confidential should any of the information be included in their program reports.

_____
Signature

Witness_____

Date_____

Time_____

0057

Elsie M. Pinkston, Ph.D. , Principle Investigator
Rosemary Nelson Young, M.A., C.S.W., Program Director

Elderly Support Project
The University of Chicago
969 East Sixieth Street
Chicago, IL 60637

Consent by Staff and Family

I,_____agree to participate in the Elderly Support Project. This opportunity has been offered to me through the University of Chicago, School of Social Service Administration. The project has been explained to me and I have been allowed to ask questions. I understand that I can withdraw my consent to participate at any time. I further understand that results of the program may be presented orally and published but that my identity will be held confidential.

_____
Signature

Witness_____

Date_____

Time_____

Elsie M. Pinkston, Ph.D. , Principle Investigator
Rosemary Nelson Young, M.A., C.S.W., Program Director

APPENDIX B

Staff Training--Assessment 1 and 2

Behavioral Knowledge Inventory
Index of Organizational Reaction
Skills Assessment Forms

Behavioral Training for Adult Day Care Staff and Families

Overview

Orientation and Assessment (approx. 2 weeks, to be scheduled individually)

1. Reinforcement Survey Date_____Time_____
2. Reinforcement Task Date_____Time_____
3. Task Analysis Date_____Time_____
4. Cueing Date_____Time_____
5. Activities Programming Date_____Time_____
6. Contracting Date_____Time_____
7. Group Skills Date_____Time_____
8. Reinforcing Incompatible Behavior Date_____Time_____
9. Skill Development and Recovery Date_____Time_____
10. Choosing an intervention Date_____Time_____

Assessment (Approx. 2 weeks to be scheduled individually)

11. Intervention Consultation Date_____Time_____
12. Intervention Consultation Date_____Time_____
13. Intervention Consultation Date_____Time_____
14. Intervention Consultation Date_____Time_____
15. Intervention Consultation Date_____Time_____

Assessment Session 1: Overview of Staff Training

Setting_____Trainer_____

1. Describe training program

   ___A. Sessions 1-10 are devoted to developing behavioral technology skills.

   ___B. Sessions 11-15 are devoted to staff consultation about specific case plans.

   ___C. Sessions 16-20 are for group family training. Only staff who wish to do so will be included.

2. Describe brief observations

   Before Training

   ___A. Individual skill assessments to determine where training would be most useful.

   After Training

   ___B. Individual skill assessments to assess the effectiveness of the training program.

3. Explain questionnaires

   ___A. Attitude toward employment situation (note: the data is confidential and will not be shared with employer).

   ___B. Attitudes of efficacy toward specific caregiving tasks, i.e. how staff think about tasks and their ability to perform them.

   ___C. Consumer evaluation will record their satisfaction with various aspects of the training and their overall view of its usefulness.

4. Behavioral observation data (note: this will be ongoing and has usually begun by this orientation).

___A. This data determines the overall levels of client and staff behavior and will add to what is known about day centers. (Note: these data do not pick up subtle changes in staff behavior, but rather, they provide general information about social behavior in adult day care with seriously impaired individuals.

___B. Graphs of the centers' data will be shared with the staff at the end of the study.

5. Scheduling and Evaluation

___A. Two weeks of specific skill evaluations before and after training.

___B. Confidentiality will be maintained on these individual scores and they will not be shared with supervisory staff without written permission of the entire staff in each agency.

6. Family Training

___ Following the completion of the five-week staff consultation, four weeks of group family training will be conducted.

7. Interaction Between Training and Research

___A. We must delicately balance conducting a reasonable training program and contributing to the development of adult day centers.

___B. Some tasks staff will be asked to complete should enhance their personal effectiveness. Other tasks are designed to establish training effectiveness and therefore will only contribute to knowledge about the care of the elderly by daycare staff.

___C. We appreciate cooperation but would like to know when you are troubled by some aspect of the training. Please feel to discuss your concerns with the trainer, Ms. Young or Dr. Pinkston.

8. Certificate of Behavioral Management in Gerontology

_____ Staff will receive a certificate for the successful completion of training, tasks and assessment. (At least 80%)

9. Conclusion

___A. Ask for questions.

___B. Answer questions.

: SO ESP

(BPKI)

Date_____ ___Pre

Name_____ ___Post

BEHAVIOR PRINCIPLES KNOWLEDGE INVENTORY

DIRECTIONS: The following questions are designed to determine your ideas about human behavior, particularly as applied to older persons. Read each question and each of its four possible answers. Sometimes more than one could be correct under certain circumstances; however, you should select the best answer or the one that is most generally true. Completely circle the letter beside the best answer.

EXAMPLE: Probably the most important influence in a person's life is his

A. Hobbies

B. Work

C. Television

D. Friends and family

Please do not consult others while deciding how to answer the question. Be sure to circle only one letter for each question. Be sure to answer every question even if you must guess.

1. Problem behavior in older people is often

   A. Impossible to change due to deeper emotional problems.

   B. Not related to learning, as older persons are unable to learn.

   C. Learned responses based on the older person's abilities and the attention they do or do not receive.

   D. Due to the changes of old age.

2. Most behaviors can be classified as desirable or undesirable. Desirable and undesirable behaviors are <u>most alike</u> in that they are:

   A. The result of emotions and feelings.

   B. Habits and therefore difficult to change.

   C. Ways people express themselves.

   D. The result of learning.

3. If you were trying to encourage a very silent older person to talk more, you should first:

   A. Compliment the older person after each conversation.

   B. Compliment the older person for saying a sentence.

   C. Compliment the older person for saying a word or any vocalization.

   D. Criticize the older person for being so quiet.

4. An older person is having a difficulty with housekeeping. Family members

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have encouraged the person to clean by praising and complimenting the older person each time he or she does any housekeeping activity. The next step should probably be to

A. Have a talk about how pleased you are and then not concentrate on complimenting the older person for housekeeping.

B. Try to praise the person for cleaning about once a week.

C. Praise or compliment the older person almost every time he or she cleans.

D. Continue to praise the older person every time he or she cleans.

5. When giving a compliment about a behavior, it will often be better to include

A. Physical contact such as hand holding or hugging.

B. Criticism for a behavior problem which occurred earlier.

C. Reminders of some other behavior which is not occurring.

D. Questions about what made the behavior occur.

6. Mrs. P. has noticed that since her mother began to have memory problems, she has been visiting her mother less frequently. This is probably because:

A. She believes the visits are harmful to her mother.

B. She has less time to visit her mother due to other family responsibilities

C. Her visits are no longer as rewarding to her, so she has changed her visiting behavior.

D. She no longer loves her mother.

7. Family members may ask older relatives fewer questions because

A. The relatives provide fewer or less satisfying answers.

B. Their relatives are no longer interested in responding to them.

C. They do not wish to confuse the older person.

D. They are no longer interested in what the older person has to say.

8. The following all may help increase conversation with an older person except:

A. Ask more questions.

B. Allow more time for the older person to respond.

C. Point out to the older person that their talking has gotten worse.

D. Bring pictures or interesting items to the older person to discuss togeth

9. An older man is beginning to redress himself while recovering from a stroke. You notice he is having a difficult time and want to encourage him. When would it be most helpful for you to first encourage or praise him for his progress?

A. When he has completely finished dressing himself.

B. When he asks to be allowed to try to dress himself.

C. When he gets his underwear completely on.

D. When he makes the first step in putting on his underwear.

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10. The first step in eliminating a problem behavior is to:

    A. Carefully observe the behavior.
    B. Compliment the person when he is not exhibiting the behavior.
    C. Punish the person for misbehavior.
    D. Seek help from someone who is more objective.

11. Which of the following is <u>not</u> an important step in a behavior change program?

    A. Be sure the older person feels ashamed of his misbehavior.
    B. Decide on a particular behavior that you wish to change.
    C. Break the selected behavior down into smaller steps.
    D. Select a proper time and place for measuring the behavior.

12. The Brown family is very concerned about their father, whose behavior has changed since his 80th birthday. He often gets lost when outside the house, complains frequently, has become argumentative, no longer dresses properly, and is forgetful. The best approach to begin to help with these behavior problems is:

    A. Try to quickly eliminate all of these problems at once.
    B. Select a few problems to deal with first.
    C. Select the <u>one</u> behavior which is the biggest problem and concentrate on changing that first.
    D. Wait about a month before beginning to try to help with these problems to be sure they are stable and persistant.

13. Which would be the best example of a way to praise an older person who has demonstrated improvement in his walking?

    A. Good.
    B. I love you.
    C. You are doing much better. You should be walking by yourself within a month or so.
    D. I really like the way you are using your cane. You are holding it in the middle of the handle and placing it directly on the floor.

14. A major problem has been for Mrs. Smith to spend more time out of her bed. Her husband, Mr. Smith, wants to help her to change this and wants to measure the relevant behaviors. Which is the best way to do this?

    A. Each day record when she has spent time out of bed.
    B. Record her behavior <u>all day long</u> to determine what occurs before, during, and after the time she is in bed.
    C. Each week, make note of how easy or difficult it is for her to get out of bed.
    D. Require Mrs. Smith to keep her own record each week.

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15. The Jones family is concerned about their grandmother's constant complaining. Which of the following methods would usually be the best technique to reduce the number of complaints?

A. Explain to Grandmother why the behavior is undesirable as well as why they think she needs to complain so much.

B. Watch for times when Grandmother is not complaining (talking about other things). When this occurs praise or compliment her and engage in discus.

C. Criticize Grandmother when she complains and remind her to stop complaining.

D. Try to avoid talking to Grandmother altogether.

16. If an older person receives less and less attention or praise for a behavior, what is most likely to happen?

A. He or she may behave that way less and less.

B. He or she will be more likely to behave that way for a long time.

C. He or she will learn to distrust those who have been giving less attention or praise.

D. He or she may increase the behavior.

17. How often a behavior occurs is probably most related to:

A. The person's attitude about his or her behavior.

B. What happens to the person at the same time the behavior occurs.

C. What happens to the person just before the behavior occurs.

D. What happens to the person just after the behavior occurs.

18. Which of the following is true about criticizing a person for their behavior?

A. Criticism shows concern and respect for the person.

B. Criticism should be delayed until it can be carefully determined that it is really necessary.

C. Criticism can be used to teach new skills or behaviors.

D. A person who is criticized may then become upset or aggressive and may develop additional undesired behaviors.

19. The most likely reason older persons would show undesirable behavior in the presence of other family members is:

A. They are expressing anger.

B. They learned to behave this way and that it will receive attention.

C. The misbehavior is due to the changes of aging.

D. They have not been told that their behavior is undesirable.

20. If you want to make a behavior a long-lasting habit, you should:

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A. Compliment or reward it each time it occurs.

B. First reward it every time and later reward it occasionally.

C. Promise some pleasant event or gift if it occurs.

D. Give several reasons why the behavior is important and remind the person of these reasons frequently.

21. To record, graph, and note the direction of the change of a behavior is:

A. A minor, optional step in a behavior change program.

B. An important step in a behavior change program.

C. A procedure employed only by scientists for research reasons.

D. Time consuming and complicated and useful only in special cases.

22. The best explanation of why many older people have few activities to engage in

A. They no longer are interested in activities.

B. They are not rewarded for engaging in activities.

C. They have become grouchy and lost friends.

D. They believe they cannot do any of the expected activities.

23. As older people lose their abilities to see, move, hear, and taste,

A. They receive more attention and rewards.

B. They receive fewer rewards and attention.

C. They do not notice the change in abilities.

D. They note the change but are not interested or do not care.

24. When people get older, they

A. Are more sensitive to the taste of foods.

B. Are less sensitive to the taste of foods.

C. Complain more about food because they are unhappy.

D. Have no change in sensitivity to taste.

25. One reason depression occurs in older persons is:

A. Life becomes overwhelming.

B. The older person no longer cares about living.

C. Older persons generally become very angry.

D. Enjoyed activities are lost or occur infrequently.

26. Once a new behavior is learned, to help continue the behavior it is important to:

A. Avoid calling attention to the behavior as the person has successfully learned it.

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B. Scold the person if he or she seems to forget to engage in the behavior

C. Reward or praise the person when he or she does engage in the behavior.

D. Ignore the behavior as further attention to the behavior may embarrass the person.

27. Because of arthritis, Mrs. B. has difficulty in continuing her favorite activity of hand sewing. Her family should:

A. Take her sewing materials away as they will depress her.

B. Ignore this problem entirely.

C. Let her sew and correct it when she is asleep.

D. Encourage other activities without emphasizing her sewing.

28. Mrs. M. often cries, usually over small things. Her relatives should:

A. Find out the reasons for her crying.

B. Compliment her and talk with her when she is not crying.

C. Talk to her if she cries.

D. Help her avoid things that upset her.

29. Compliments are most effective when:

A. Used prior to the behavior occurring.

B. They are not given in connection with a particular behavior.

C. Given immediately after the behavior occurs.

D. Given fifteen minutes after the behavior occurs.

30 Successful change depends most on:

A. Changing the attitudes of the older person.

B. Understanding the limitations of old age.

C. Careful attention to the events that occur before and after a behavior.

D. How long the prior behavior has persisted.

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Adapted from KSPAC. O'Dell et. al., 1979

Index of Organizational Reaction

1	3
2	4

PLACE AN "X" BEFORE THE ONE RESPONSE TO EACH QUESTION THAT BEST DESCRIBES YOUR FEELING OR OPINION.

1. The people who supervise me have:
___ 1. Many more good work habits than bad
___ 2. More good work habits than bad
___ 3. Same number of good and bad work habits
___ 4. More bad work habits than good
___ 5. Many more bad work habits than good

2. The supervision I receive is the kind that:
___ 1. Greatly discourages me from giving extra effort
___ 2. Discourages me from giving extra effort
___ 3. Has little influence on me
___ 4. Encourages me to give extra effort
___ 5. Greatly encourages me to give extra effort

3. How does the way you are treated by those who supervise you influence your overall attitude toward your job? It has:
___ 1. A very unfavorable influence
___ 2. An unfavorable influence
___ 3. No real effect
___ 4. A favorable influence
___ 5. A very favorable influence

4. How much do your supervisors add to the success of your unit?
___ 1. A very great deal
___ 2. Quite a bit
___ 3. Only a little
___ 4. Very little
___ 5. Almost nothing

5. How do you feel about the supervision you receive? I am:
___ 1. Very satisfied
___ 2. Well satisfied
___ 3. Only moderately satisfied
___ 4. Somewhat dissatisfied
___ 5. Very dissatisfied

6. How often do you feel you could do a better job if you were treated differently by people who supervise you?
___ 1. Almost always
___ 2. Frequently
___ 3. Occasionally
___ 4. Seldom
___ 5. Never

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7. How much of the work you do stirs up real enthusiasm on your part?
___ 1. Nearly all of it
___ 2. More than half of it
___ 3. About half of it
___ 4. Less than half of it
___ 5. Almost none of it

8. How many of the things you do on your job do you enjoy?
___ 1. Nearly all
___ 2. More than half
___ 3. About half
___ 4. Less than half
___ 5. Almost none

9. How does the kind of work you do influence your overall attitude toward your job? It has:
___ 1. A very unfavorable influence
___ 2. A slightly unfavorable influence
___ 3. No influence one way or the other
___ 4. A fairly favorable influence
___ 5. A very favorable influence

10. How do you feel about the kind of work you do?
___ 1. Don't like it, would prefer some other kind of work
___ 2. It's OK, there's other work I like better
___ 3. I like it, but there is other work I like as much
___ 4. I like it very much
___ 5. It's exactly the kind of work I like best

11. How often when you finish a day's work do you feel you've accomplished something really worthwhile?
___ 1. All of the time
___ 2. Most of the time
___ 3. About half of the time
___ 4. Less than half of the time
___ 5. Rarely

12. Work like mine:
___ 1. Greatly discourages me from doing my best
___ 2. Discourages me from doing my best
___ 3. Makes little difference
___ 4. Encourages me to do my best
___ 5. Greatly encourages me to do my best

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13. I feel my workload is:

____1. Never too heavy
____2. Seldom too heavy
____3. Sometimes too heavy
____4. Often too heavy
____5. Almost always too heavy

14. How do you feel about the amount of work you're expected to do?

____1. Very dissatisfied
____2. Somewhat dissatisfied
____3. Neither satisfied nor dissatisfied
____4. Somewhat satisfied
____5. Very satisfied

15. How does the amount of work you're expected to do influence your overall attitude toward your job? It has:

____1. A very favorable influence
____2. A favorable influence
____3. No influence one way or the other
____4. An unfavorable influence
____5. A very unfavorable influence

16. How does the amount of work you're expected to do influence the way you do your job?

____1. It never allows me to do a good job
____2. It seldom allows me to do a good job
____3. It has no effect on how I do my job
____4. It usually allows me to do a good job
____5. It always allows me to do a good job

17. How do you generally feel about the employees you work with?

____1. They are the best group I could ask for
____2. I work well with them
____3. I have no feeling one way or the other
____4. They are sometimes hard to work with
____5. They are often very hard to work with

18. How is your overall attitude toward your job influenced by the people you work with? It is:

____1. Very favorably influenced
____2. Favorably influenced
____3. Not influenced one way or the other
____4. Unfavorably influenced
____5. Very unfavorably influenced

19. The example my fellow employees set:

____1. Greatly discourages me from working hard
____2. Discourages me from working hard
____3. Has little effect on me
____4. Encourages me to work hard
____5. Greatly encourages me to work hard

20. How much does the way co-workers handle their jobs add to the success of your unit? It adds:

____1. Almost nothing
____2. Very little
____3. Only a little
____4. Quite a bit
____5. A very great deal

21. Among employees in this unit, there is:

____1. A great deal of friction
____2. Quite a bit of friction
____3. Some friction
____4. Little friction
____5. Almost no friction

22. How does the amount of money you now make influence your overall attitude toward your job? It has:

____1. A very favorable influence
____2. A fairly favorable influence
____3. No influence one way or the other
____4. A fairly unfavorable influence
____5. A very unfavorable influence

23. Does the way pay is handled (administered) around here make it worthwhile for a person to work especially hard?

____1. It definitely encourages hard work
____2. It tends to encourage hard work
____3. It makes little difference
____4. It tends to discourage hard work
____5. It definitely discourages hard work

24. Considering what it costs to live in this area, my pay is:

____1. Very inadequate
____2. Inadequate
____3. Barely adequate
____4. Adequate
____5. More than adequate

25. How many of your needs are satisfied by the pay and benefits you receive?

__1. Almost none of my needs are satisfied
__2. Very few of my needs are satisfied
__3. A few of my needs are satisfied
__4. Many of my needs are satisfied
__5. Almost all of my needs are satisfied

26. For the job I do, I feel the amount of money I make is:

__1. Very good
__2. Good
__3. Neither good nor poor
__4. Poor
__5. Very poor

27. How much pride can you take in the appearance of your unit?

__1. A very great deal
__2. Quite a bit
__3. Some
__4. Little
__5. Very little

28. How do you feel about your physical working conditions?

__1. Very satisfied
__2. Well satisfied
__3. Only moderately satisfied
__4. Somewhat dissatisfied
__5. Very dissatisfied

29. For the work I do, my physical working conditions are:

__1. Very poor
__2. Relatively poor
__3. Neither good nor poor
__4. Relatively good
__5. Very good

30. How do your physical working conditions influence your overall attitude toward your job? They have:

__1. A very unfavorable influence
__2. An unfavorable influence
__3. No influence one way or the other
__4. A favorable influence
__5. A very favorable influence

31. The physical working conditions make working here:

____1. Very unpleasant
____2. Unpleasant
____3. Neither pleasant nor unpleasant
____4. Pleasant
____5. Very pleasant

32. How do your physical working conditions affect the way you do your job?

____1. They help me a great deal
____2. They help a little
____3. They make little difference
____4. They tend to make it difficult
____5. They make it very difficult

33. How do your feelings about your future with the organization influence your overall attitude toward your job? They have:

____1. A very favorable influence
____2. A favorable influence
____3. No influence one way or the other
____4. A slightly unfavorable influence
____5. A very unfavorable influence

34. How do you feel about your future with the organization?

____1. I am very worried about it
____2. I am somewhat worried about it
____3. I have mixed feelings about it
____4. I feel good about it
____5. I feel very good about it

35. The way my future with the organization looks to me now, hard work seems:

____1. Very worthwhile
____2. Fairly worthwhile
____3. I have mixed feelings about it
____4. Hardly worthwhile
____5. Not at all worthwhile

36. Do you feel you are getting ahead in the organization?

____1. I'm making a great deal of progress
____2. I'm making some progress
____3. I have mixed feelings about it
____4. I'm making very little progress
____5. I'm making no progress

37. How secure are you in your present job?

____1. I feel very uneasy about it
____2. I feel fairly uneasy about it
____3. I have mixed feelings about it
____4. I feel fairly sure of it
____5. I feel very sure of it

38. When this organization makes decisions, how much concern does it show for employee welfare?

____1. A very great deal
____2. Considerable
____3. Some
____4. Little
____5. None

39. How would you describe this organization as an employer?

____1. Couldn't be much better
____2. Very good
____3. Neither good nor poor
____4. Just another place to work
____5. Couldn't be much worse

40. How does working for this organization influence your overall attitude toward your job? It has:

____1. A very unfavorable influence
____2. An unfavorable influence
____3. No influence one way or the other
____4. A favorable influence
____5. A very favorable influence

41. From my experience, I feel this organization treats it employees:

____1. Quite poorly
____2. Moderately poorly
____3. Neither poorly nor well
____4. Moderately well
____5. Quite well

42. There is something about working for this organization that:

____1. Strongly encourages me to do my best
____2. Encourages me to do my best
____3. Neither encourages nor discourages me
____4. Discourages me from doing my best
____5. Strongly discourages me from doing my best

ESP ADC STAFF TRAINING

INTRODUCTION
ESP 5/22 /86
PRETEST/POSTTEST

We are going to ask you to engage in four different exercises. These exercises will help us to determine how to make the training most useful. It will also provide us with information needed for the ongoing research program. Please attempt to complete each exercise as best you can.

(TRAINEE FORM)

ESP ADC STAFF TRAINING

BEHAVIORAL CONTRACTING
ESP 5/22/86
PRETEST/POSTTEST

For this exercise, please NEGOTIATE A WRITTEN BEHAVIORAL CONTRACT with an ADC client that focuses on increasing a desirable behavior.

I will let you know when 10 minutes are up.

(TRAINEE FORM)

ESP ADC STAFF TRAINING

TASK ANALYSIS
ESP 5/22/86
PRETEST/POSTTEST

For this exercise, please complete a TASK ANALYSIS.

In other words, prepare written instructions which will assist you in helping a client accomplish a behavior or activity.

Pretend that you are trying to increase a client's involvement in a selected behavior or activity. List the steps that you and the client would take to do this.

I will let you know when 10 minutes are up.

Task analysis:

(TRAINEE FORM)

ESP ADC STAFF TRAINING

CUEING TASK
ESP 5/22/86
PRETEST/POSTTEST

For this exercise, please use CUEING, that is, verbal or physical instructions to encourage a particular client to engage in a behavior.

Choose five behaviors to cue. These behaviors may be related to a single activity or to different activities.

Write down the name of the client and the activity chosen, and then proceed.

I will let you know when eight minutes are up.

Client:

Activity:

(TRAINEE FORM)

ESP ADC STAFF TRAINING

REINFORCEMENT TASK
ESP 5/22/86
PRETEST/POSTTEST

For this exercise, please use REINFORCEMENT PROCEDURES with three different clients.

We are defining a reinforcement procedure as anything that you would do to strengthen or increase the future probability of a behavior.

First, write the names of three clients with behaviors to be reinforced.

Next, for each client, write down the behavior to be reinforced.

Return the list to me, and proceed with the task. I will let you know when six minutes are up.

Client 1:

Behavior to be reinforced:

Client 2:

Behavior to be reinforced:

Client 3:

Behavior to be reinforced:

(TRAINER FORM)

ESP ADC STAFF TRAINING

REINFORCEMENT TASK
Staff Observation Form
ESP 5/22/86
PRETEST/POSTTEST

Trial length_____ Observer_____

Center_____ Staff member_____

Date_____ Client_____

Staff member's behavior: Check (√) below if performed.

1. Selects a client_____

2. Identifies behavior
   to be reinforced_____

3. Delivers reinforcement
   contingently:

   A. Direct reinforcement_____
      (List)

   B. Indirect reinforcement_____
      (List)

(TRAINER FORM)

ESP ADC STAFF TRAINING

CUEING EXERCISE
Staff Observation Form
ESP 5/22/86
PRETEST/POSTTEST

Trial length_____ Observer_____

Center_____ Staff member_____

Date_____ Client_____

Staff member's behavior: Check (√) below if occurred. Write N/A if not applicable.

1. Gets client's attention_____
2. Gives clear instruction:
   A. Verbal instruction_____
   B. Modeling_____
   C. Environmental prompt_____
3. Waits 30 seconds_____
4. Repeats once_____
5. Offers no other verbal cues_____
6. Offers physical guidance 10 seconds after the repetition_____

(TRAINER FORM)

ESP ADC STAFF TRAINING

TASK ANALYSIS
Staff Assessment Form
ESP 5/22/86
PRETEST/POSTTEST

Trial length_____ Observer_____

Center_____ Staff member_____

Date_____ Client_____

Included in task analysis: Check (√) below if included.

1. Selects a client with a desired behavior(s) to be increased_____
2. Describes the behavior(s) to be increased_____
3. Lists the steps the client will need to carry out in order to accomplish the behavior. (If the client has memory loss or is confused, be sure that no step requires more than one response from the client for each instruction.)_____
4. Lists the necessary materials the client may need to carry out the behavior(s)_____
5. Lists staff instructions in steps or cues to the client regarding the desired behavior(s)_____
6. Describes circumstances under which the client is most likely to be successful in accomplishing the behavior_____

(TRAINER FORM)

ESP ADC STAFF TRAINING

BEHAVIORAL CONTRACTING
Staff Recording Form
ESP 5/22/86
PRETEST/POSTTEST

Trial length_____ Observer_____

Center_____ Staff member_____

Date_____ Client_____

Staff member's behavior: Check (√) below if performed.

1. Selects a client_____
2. Gets client's attention_____
3. Identifies for the client the task or activity to be performed_____
4. Specifies the subtasks to be completed by the client_____
5. Specifies the subtasks to be completed by staff_____
6. Specifies:
   A. when (time, day)_____
   B. where_____
   C. Who will participate_____
7. Specifies the consequences contingent on completing the task_____
8. Specifies when the consequences will be delivered_____
9. Completes a written contract_____

APPENDIX C

Staff Training--Sessions 1-10

SESSION 1: REINFORCEMENT SURVEY*

___1. Explain, once more, that the training program is based on behavioral principles. The principle most frequently used in designing programs or interventions for the elderly is reinforcement. During the first two sessions the skills taught are directed toward the identification and application of direct and indirect reinforcers.
Definition of "reinforcement": A consequence to a behavior that is likely to strengthen or increase that behavior in the future is called a reinforcer.

___2. There are two assignments. The first assignment is to administer the Elderly Reinforcement Survey Schedule to one of the clients with a consent form in the day center. The second is to administer a Reinforcement Survey to yourself. The purpose of the Elderly survey is to teach you more about the potential reinforcers to use with the client. The second is to make you aware of the reinforcers you like and to encourage you to use more of them to increase your personal satisfaction.

___3. Before we begin, I would like for you to list as many reinforcers for the client you will be surveying that you can think of today.

*Note: The order of presentation is optional. What is important is a positive warm attitude and specific verbal behavior.

___4. Here is the Elderly Reinforcement Survey Schedule. When administering the questionnaire, choose a time when the client seems relaxed. Ask if you can talk about things the client enjoys, like certain activities or foods. Tell the client the information will be used in planning programs. Find a comfortable place where you can talk. State that you will be asking how much the client enjoys a particular experience by having the client answer: not at all; a little; a fair amount; much; or very much. Assure the client that this is not a test and there are no right or wrong answers. We are simply interested in knowing what the client enjoys at this time of life.

___5. At least once during the training session it will be important to praise both the staff and to note positive aspects of the center. Drawing examples of positive observations you have made during the past weeks will model good reinforcement techniques to the staff.

List other items you added that you think would be useful to include in the outline--be creative. Particular examples you used that will strike a chord of approval would be a useful contribution.

REINFORCEMENT TASK

1____ Select 3 clients engaged in some activity, preferably with materials, or behaving in a positive way.

2____ Choose a particular client behavior to reinforce.

3____ Praise directly to the client the selected behavior as specifically as possible either while the behavior is occurring or as soon as possible after it is finished.
(This is called direct reinforcement.)

4____ Praise indirectly the client by saying something positive about his/her behavior to another client or to a staff member within the hearing of the client. (This is called indirect reinforcement.)

SESSION 2: REINFORCEMENT TASK

___1. Review the Elderly Reinforcement Survey Schedule and the staff's Reinforcement Survey. Ask what reinforcers they discovered that the client liked. You might note that in previous research, staff have tended to overvalue food when working with the elderly.

___2. Discuss what they learned about their own reinforcers by taking the Reinforcement Survey.

___3. Ask what reinforcers they might include in the day center that are not presently available.

___4. Discuss the reinforcement task as an assignment designed to increase their facility for using reinforcement procedures.

___5. The first reinforcement skill is to administer positive consequences following a behavior.

___6. To accomplish this the staff will use the Reinforcement Task outline and follow these instructions:

___A. Select 3 clients engaged in some activity, preferably with materials, or behaving in a positive way.

___B. Choose a particular client behavior to reinforce. (It need not be different for each client but that would be a good idea.)

___C. Praise directly to the client the selected behavior as specifically as possible either while the behavior is occurring or as soon as possible after it is finished. (This is called direct reinforcement.)

___D. Praise indirectly the client by saying something positive about his/her behavior to another client or to a staff member within the hearing of the client. (This is called indirect reinforcement.)

___E. Evaluate your performance as a reinforcing person. What do you like best about your performance. do you think you could improve? How?

___7. During the Reinforcement Task the trainer should follow the staff and provide appropriate positive feedback at natural breaks away from the client.

___8. Be very enthusiastic about their performance and very behaviorally specific in identifying their specific reinforcement skills, i.e., good affect, very specific, original, warm, good immediate consequence etc.

___9. If it is possible begin next session with a review of this exercise.

Add techniques you used not listed here.

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(This is called direct reinforcement.)

4____ Praise indirectly the client by saying something positive about his/her behavior to another client or to a staff member within the hearing of the client. (This is called indirect reinforcement.)

SESSION 3: TASK ANALYSIS

___1. The Task Analysis skill is to help you define client behaviors in an objective and observable way using small increments of behavior. For instance we know that Alzheimer's clients who are somewhat advanced in the illness respond to single clear instructions. Therefore, in order for them to experience achievement and success it will be necessary to design a series of tasks that will lead to the achievement of a larger task. This will be useful in keeping people engaged in the task and in improving your communication.

___2. The first part of Task Analysis is to decide what the resulting behavior(s) will be if your intervention is successful.

___3. The second part of Task Analysis is to define the behavior or behaviors that are to be increased.

___4. Define and list specific steps that are to be accomplished to carry out the desired behavior. (Provide examples.)

___5. If it is an activity involving materials, list materials needed to engage in the activity or, if not, who needs to be present to conduct the activity.

___6. List the instructions that will be needed to aid the client or list other environmental cues that will be necessary such as a clock or checklist.

___7. Describe the circumstances under which you believe the client will most likely to be successful in accomplishing the behaviors, such as the time, location, who will be present, or any special consequences that will be available.

___8. Once you are good at conducting a Task Analysis you will have the basis for most teaching, rehabilitation, reinforcement, or shaping programs. This skill will help you to determine your expectations and to ask for what you want.

TASK ANALYSIS OF CLIENT BEHAVIOR

___1. Select a client with a desireable behavior(s) to be increased.

___2. Describe the behavior(s) to be increased.

___3. List the steps the client must carry out to accomplish the behavior(s). (If client has memory loss or confusion, be sure each step requires only one response from the client for each simple staff instruction.)

___4. List staff instructions, in steps or cues, that are related to the steps the client must carry out to accomplish the behavior. List the staff instructions next to the corresponding client step.

Client Steps	Staff Instructions

___5. List materials the client needs to carry out the behavior(s).

___6. Describe circumstances under which the client is most likely to be successful in accomplishing the behavior(s).

SESSION 4: CUEING--INSTRUCTION GIVING

___1. Cueing and instruction giving overlap to some degree with the task analysis skill you have just covered. Today we will implement a training procedure using the information and techniques gained in that process. This assignment will sharpen the way you implement a task intervention.

___2. Hand out the task outline and go over it together.

___3. Staff does the exercise with client. Trainer observes and gives positive feedback.

___4. Ask staff to evaluate their performance: What did they do well? What would they do differently next time? What did they learn about how they give instructions?

___5. After completing the exercise, ask how the staff would have accomplished the same task if you had to use visual cues?

___6. Walk staff through the facility, indicating the various visual cues that are present at the facility.

CUEING--INSTRUCTION GIVING

___1. Prepare instructions for client (See Task Analysis).

___2. During this exercise, note the duration between instruction and compliance with instruction ___

___3. Cueing Exercise.

For each behavior:

___a. Get client's attention.

___b. Give a clear instruction.

___c. Wait 30 seconds.

___d. If client does not respond, repeat instruction once (give no other verbal cues).

___e. Wait 10 more seconds.

___f. If client does not respond, give physical help.

___4. Observe client response(s):

___a. Client responds to instructions within 30 seconds.

___b. Client responds after repetition of instruction.

___c. Client responds with help.

___5. Evaluate your performance. What did you like about the way you did this cueing exercise? What did you learn about your own instruction giving? What would you do differently next time?

SESSION 5: ACTIVITY PROGRAMMING

___1. Thus far in our research, activities appear to be the most socially motivating events in adult daycare. Activities enable the staff to increase the rate of client response through the use of questions or instructions to the individual or group. Successful planning has numerous benefits, such as lowering rates of wandering and aggressive behavior.

___2. Please plan an activity of 10 to 20 minutes using the following outline. You may plan a new activity or use an old activity. Please plan an activity that includes social responses as opposed to activities such as Bingo or Exercise class. (See attached examples.)

___3. When you plan the activity, decide who is likely to participate. Things to consider include the degree of impairment. Alzheimer's and other memory loss individuals will likely benefit from activities that require only <u>one</u> response at a time. In very impaired individuals it may be important to help them locate the part of their body that they need to use to follow your instructions, e.g. their hands or feet, before proceeding.

___4. This is a good time to remember what you learned in Task Analysis, and to decide how small the behavioral steps must be and how simple and clear your instructions must be to allow the client a successful outcome.

___5. In order to develop a plan (perhaps to be included in an activities notebook) the following steps are useful to consider:

___a. What is the activity?

___b. Short-term Goals (This includes the purpose of the activity itself and also what the client's experience today will be.)

___c. Long-term Goals (What will the client ultimately learn or relearn?)

___d. Who (staff and clients) will participate?

___e. Who will be responsible for advance preparation (materials, set-up, etc.)

___f. When will the activity occur? (time and day)

___g. Where will the activity take place?

___h. What procedures will be used?

___i. Who will record accomplishment of defined tasks?

___6. Trainer observes activity when possible and gives positive feedback. (Pair up staff when appropriate.)

___7. Discuss with staff their evaluation of the effectiveness of the activity and any improvements they might make in the future. Be sure to find out what they particularly liked about the activity.

ACTIVITY PLAN

CENTER_____ DATE_____

DUE DATE_____

WHAT is the activity_____

Goals:

Short-term Goal(s)_____

_____

Long-term Goal(s)_____

_____

_____

WHO will participate:

Staff_____ _____

_____ _____

_____ _____

Clients_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

WHO will be responsible for these:

Who will get materials_____

Materials needed_____

_____

_____

Who will set up_____

WHEN will it take place (time and day)_____

WHERE will it take place_____

0098

PROCEDURES:

Who will record the accomplishment of the defined tasks?

Name(s)_____

ACTIVITY DESIGNER_____

SESSION 6: CONTRACTING WITH CLIENTS

___1. Contracts with the impaired elderly must be kept simple, clear and direct. The format is a relatively simple one using a sort of "party-invitation" format of who? what? where? and when? Often we assume that clients know what they are supposed to do and are motivated to do it when, in fact, they do not. The contract helps both staff and client to understand expectations and consequences.

___2. When developing a contract with a client, it is important to understand the degree of impairment. The more impaired the individual, the simpler and more immediate the contract should be.

___3. For our purposes, contracts are written agreements. Even if the client can't read, a written contract will let staff be aware of the agreement.

___4. Using skills developed in task analysis, the difficulty of tasks and the number of tasks to contract for should be carefully considered.

___5. Using information learned during the reinforcement exercises, decide what positive consequence will be provided following the performance of the contracted behaviors. Sometimes this will merely be social attention or a special activity. Rarely will material rewards be used except with the most impaired clients. There is nothing wrong with material rewards but they often are not convenient.

___6. Give out the Contracting outline to staff and discuss.

___7. Have staff complete a written contract with a client:

___1. Choose a client.

___2. Sit down with the client and get the client's attention.

Then, for the contract itself:

___3. Discuss and decide with client the task or activity to be completed.

___4. Specify the behaviors or actions to be carried out by the client.

___5. Specify what the staff will do to facilitate the client's completing the task or activity.

___6. Specify when the task is to occur (day and time).

___7. Specify where the task is to occur.

___8. Specify who else is to participate.

___9. Specify the consequences contingent upon completing the task.

___10. Specify when the consequences will be delivered.

___11. Complete the written contract with the client.

___8. Have staff evaluate the contract. How did it work? Were the consequences delivered? What needs to be modified? What did they like about the technique? What did they dislike?

___9. Have staff evaluate their performance.

CONTRACTING

___1. Choose a client.

___2. Sit down with the client and get the client's attention.

Then, for the contract itself:

___3. Discuss and decide with client the task or activity to be completed.

___4. Specify the behaviors or actions to be carried out by the client. (See task analysis, activity procedures.)

___5. Specify what the staff will do to facilitate the client's completing the task or activity.

___6. Specify when the task is to occur (day and time).

___7. Specify where the task is to occur.

___8. Specify who else is to participate.

___9. Specify the consequences contingent upon completing the task.

__10. Specify when the consequences will be delivered.

__11. Complete the written contract with the client.

SESSION 7: GROUP SKILLS TRAINING

___1. Groups skills are important in the daycare of elderly individuals. Conducting groups with the cognitively impaired elderly requires a special understanding of task analysis, stimulus cueing and positive reinforcement.

___2. It is particularly important to decide on the goals for the group activity and to decide on how you will bring those goals about. Usually, participation by group members is a group goal. An issue to consider is how nonverbal clients may participate.

___3. Care must be taken so that the low response rate by group members does not shape staff into doing all of the talking and instructing, thus resulting in the group being conducted more like a class than like a group.

___4. Ways of increasing participation of group members:

___a. In a discussion group, select topics appropriate to group members' interests. The inclusion of interesting topics usually associated with previous experiences, such as pets, war, and child rearing, appear to increase client responding. (Ask staff for some good ones.)

___b. Ask questions. To achieve verbal responding, questions seem to work best. Questions have been shown to increase alertness and conversation even with the severely impaired. In general, one question yields one response. Questions can be asked of the whole group or directed at individuals. You may need to divide up the group at times so that the more cognitively impaired group members will have the opportunity to respond and so that the others won't become bored.

___c. Keep questions at an appropriate level of difficulty.

___d. Use transition statements. Questions can be built upon a client's answer to a previous question. A "thank you" or the asking of another question building on a group member's response is one way of reinforcing client behavior, and also allows one to move on to the next person. (Ask staff for examples.)

___e. Reinforce client responses. It is important for the group leader to frequently provide a positive social consequence following group members' responses. (Ask staff to list various ways of doing this.)

___f. Use environmental cues or prompts. (Ask staff for examples.)

___g. Use task analysis where physical participation is required, so that requests are made for taking one step at a time. When the goal of your group requires a physical response, it is useful to use the task analysis plan to design the group to elicit maximum responding. Be sure you understand the number and difficulty of responses expected of the group members.

___h. Speak loudly enough.

___5. The following steps will aid you in planning group activities:

___a. Define the group goals.

___b. Define the behaviors desired from the group members.

___c. Specify what staff will do to elicit those behaviors.

___d. Specify distractions and obstacles that might prevent those behaviors from occurring:

1. Staff behavior.
2. Environmental distractions.
3. Group member's physical or mental condition.
4. Other things.

___e. Promote participation:

1. Arrange group membership to pro
2. List verbal cues or questions to b staff/clients.
3. List environmental cues/prompts
4. Determine reinforcers to reward

___6. When conducting the group use what you have c and reinforce participation.

___7. I will observe your group and provide feedback techniques you use particularly well. More tha develop each group if desired.

After the group has been conducted:

___8. Evaluate your and the group members' performa

___a. Were you prepared?

___b. How many people participated at least

___c. Did all members participate? If not, w

___d. Did you ask questions?

___e. Did you reinforce appropriate response

___f. Did you talk loudly enough?

___g. Is there anything you would do differen

___9. To be a truly reinforcing person group leader, develop new ways of commenting favorably abo clothing, their family, and their performance, t staff to indicate what they would like to hear would really make them feel good about themse people they are with.)

BEST COPY AVAILABLE

GROUP SKILLS

Ways of increasing participation of group members:

A. In a discussion group, select topics appropriate to group members' interests.

B. Ask questions.

C. Keep questions at an appropriate level of difficulty.

D. Use transition statements. Questions can be built upon a client's answer to a previous question.

E. Reinforce client responses.

F. Use environmental cues or prompts.

G. Use task analysis where physical participation is required, so that requests are made for taking one step at a time.

H. Speak loudly enough.

The following steps will aid you in planning group activities:

A. Define the group goals.

B. Define the behaviors desired from the group members.

C. Specify what staff will do to elicit those behaviors.

D. Specify distractions and obstacles that might prevent those behaviors from occurring, and how they might be corrected:

1. Staff behavior.
2. Environmental distractions.
3. Group member's physical or mental condition.
4. Other things.

E. Promote participation:

1. Arrange group membership to promote participation.
2. List verbal cues or questions to be used by staff/clients.
3. List environmental cues/prompts staff will use.
4. Determine reinforcers to reward participation.

Evaluate your and the group members' performances:

A. Were you prepared?

B. How many people participated at least once?

C. Did all members participate? If not, why didn't they?

D. Did you ask questions?

E. Did you reinforce appropriate responses?

F. Did you talk loudly enough?

G. Is there anything you would do differently next time?

SESSION 8: REINFORCING INCOMPATIBLE BEHAVIOR

___1. The purpose of this assignment is to help staff members to give attention to clients in ways that will most effectively strengthen desirable behaviors that are incompatible with negative behaviors. (Give examples of incompatible behaviors.) This skill may be easy to understand but hard to do and hard to retain as a habit. Even those of us who understand the value of this technique may get sidetracked into focusing primarily on negative or problem behaviors.

___2. To determine the incompatible behaviors you wish to strengthen or to increase, it is often necessary to rethink the situation, i.e., to retrain yourself to focus on those behaviors you would like to support rather than on those you would like to eliminate. An incompatible behavior is one that decreases the possibility that the client will engage in a negative behavior. If clients are engaged in an interesting activity it is unlikely that they will be engaged in bizarre talking, wandering, or aggressive behavior.

REINFORCING INCOMPATIBLE BEHAVIOR

To develop your skill in reinforcing incompatible behaviors, follow these steps:

___A. Ask a client, who has exhibited some troublesome behavior, to engage in a specific independent task(s). (This is a good opportunity to use your cueing skills.)

___B. Frequently praise incompatible positive behavior, stating specific details when possible.

___C. Ignore distracting, inappropriate, or negative behavior for about 10 seconds and then redirect client to positive behavior that you will reinforce. Important: this procedure is not to be used with self-injurious, combative, or other harmful behavior.

___D. Record during the exercise the frequency of your instructions, client's positive behavior and your praise using the following format:

# of Instructions	# of Client Behaviors	# of Your Praises

___E. Tally and chart the frequency of client's positive behavior and your praise. Option: If you divide your praise by client's response you can calculate your effectiveness ratio and graph that.

___F. Evaluate your performance. What felt particularly good? What would you do differently next time?

___3. To develop your skill in reinforcing incompatible behaviors, follow these steps:

___A. Ask a client, who has exhibited some troublesome behavior, to engage in a specific independent task(s). (This is a good opportunity to use your cueing skills.)

___B. Frequently praise incompatible positive behavior, stating specific details when possible.

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# of Instructions	# of Client Behaviors	# of Your Praises
////	///	//

___E. Tally and chart the frequency of client's positive behavior and your praise. Option: If you divide your praise by client's response you can calculate your effectiveness ratio and graph that.

___F. Evaluate your performance. What felt particularly good? What would you do differently next time?

SESSION 9: SKILL RECOVERY AND DEVELOPMENT PROGRAM

___1. Although having the capacity to do so, the elderly client, unlike other clients, is not learning new skills in most interventions. With the cognitively impaired older person, the skill selected for intervention is a behavioral response that was once an active part of their behavioral repertoire that the staff will help them to recover or a behavior that exists at a very low rate that the staff will help them to maintain.

___2. In many cases, tasks to be completed by the client are composed of several skills. Therefore it will be necessary to use your Task Analysis Skills format to analyze the behaviors needed for the client to participate and complete the desired task.

___3. To conduct a skill recovery program the following steps should be followed:

___A. Remove all distractions. This step is particularly important because cognitively impaired people have a fairly short attention span and are easily distracted.

___B. Use task analysis to develop response steps. Specific responses are required to insure compliance. The client must be able to do each response or must be taught that response before going on to the next step.

___C. Cue the client to practice at least two skills using at least 2 practice trials for each skill.

___D. Praise attempts to complete each step of the skill as well as the correct completed responses. Remember, this is the consequence following the response, therefore this is your chance to strengthen the client's future responses.

___E. Ignore undesired responses. Wait 10 seconds, and redirect the client.

___F. State the redirection in simple terms. Do not indicate any failure on the part of the client.

___G. Evaluate your performance.

___1. Did you divide the task into small responses?

___2. Did you praise client's attempts to respond?

___3. Did you praise correct responses?

___4. What did you like best about your performance?

___5. What would you do differently next time?

SKILL DEVELOPMENT AND RECOVERY PROGRAM

___A. Remove all distractions.

___B. Use task analysis to develop response steps.

___C. Cue the client to practice at least two response steps using at least 2 practice trials for each response.

___D. Praise attempts to complete each step of the skill as well as the completed responses.

___E. Ignore undesired responses. Wait 10 seconds, and redirect the client.

___F. State the redirection in simple terms.

___G. Evaluate your performance.

___1. Did you divide the task into small responses?

___2. Did you praise client's attempts to respond?

___3. Did you praise correct responses?

___4. What did you like best about your performance?

___5. What would you do differently next time?

SESSION 10: CHOOSING AN INTERVENTION

___1. During the previous sessions you have developed the necessary skills for conducting a behavioral intervention. During the next two weeks you will receive additional practice as we reassess those skills. Following this assessment will be a five week consultation period in which you choose individual clients for behavioral intervention.

___2. The most frequently-used intervention techniques are reinforcement and reinforcement of incompatible behavior. Sometimes, these techniques are paired with contracting and/or cueing. With some client populations, interventions are merely a rearrangement of reinforcing consequences. With the elderly, however, it is sometimes necessary to generate more reinforcers in the environment. We can never start a reinforcement intervention when adequate reinforcers are not present.

___3. When selecting a client for intervention, it is a good idea to assess the availability of reinforcers for that person and to list them.

___4. The intervention procedure begins by describing the behavior you want to change, and observing it to find out exactly what happens and how often. (Go over observation form and discuss frequency counts.)

___5. Then, analyze this information and develop a plan of intervention. (Go over the attached handouts.)

___6. Now, it is time to start thinking about the clients you will want to work with during the consultation period and to conduct some informal observations of their behaviors, looking at what happens when clients do or do not engage in the target behavior and/or when they engage in appropriate alternative behavior.

CHOOSING AN INTERVENTION

1. Describe the problem. Ask yourself these questions:

   A. What behavior needs to change? Be specific.

   B. What positive behavior(s) would you like to see? Do they happen once in a while now?

2. Observe the problem behavior and its incompatible alternative.

   Use the observation form to find out what is happening before and after the behaviors occur. Find out how often they occur by tallying this for a week or asking a family member to keep the record or just asking how often it happened last week. How often do these behaviors occur?

3. Analyze the behavior using the information obtained.

   A. What happens or what conditions exist before the problem behavior and before its positive alternative behavior occur?

   B. What happens after these behaviors occur?

4. Plan the intervention.

   Plan ways of changing any of the above before or after conditions or events so as to promote the desired behavior change including the use of appropriate behavioral techniques. (See attached checklist.)

Informal Observation:

What happens before?	The behavior	What happens after?

BEHAVIORAL INTERVENTION TECHNIQUES

___ Reinforcement

___ Task Analysis

___ Cueing

___ Contracting

___ Reinforcing incompatible behavior. Note: Only use this technique if you are giving the client lots of praise for good behavior so that you won't decrease attention to the older person and cause him/her to become upset.

___ Skill recovery and development (incorporating all of the above).

APPENDIX D

Staff Training--Individual COnsultation

Sessions 11-15
Certificate of Completion

Adult Day Center_____

Case Manager_____

Individual Rehabilitation Plan
Plan #_____

Client Name:_____

DOB:_____D/W/DD#_____Medication: Yes___No___

Res. Address:_____

Contact Person:_____Telephone #_____

Day Program:_____Contact Person:_____

Address:_____Telephone:_____

CCU/Commonagement:_____Telephone:_____

Contact Person:_____

Relative/Guardian:_____

Address:_____Telephone:_____

Disability:_____

_____

Date of Observation_____Date of Intervention_____

SESSION 11: INDIVIDUAL CONSULTATION

___1. This session is designed to begin specific behavioral interventions with clients. As in the previous session, remind the staff that they have learned to use reinforcement, task analysis, cueing, contracting, reinforcement of incompatible behavior, and recovery and development of behavioral skills.

___2. During the last session you cued the staff to begin the development of behavioral definitions and to analyze problems in an interactive way through the informal observation form, i.e., what happens before, and what happens after. If they have followed your instructions, review the specific cases that they have observed. Be sure to praise their attempts to observe the problems within a behavioral and operant framework.

___3. Tell the staff that the focus of the intervention will be on developing, maintaining or increasing positive behavior. What will the client be doing if the intervention is successful?

___4. Have the staff decide on a client to work with. Begin by having the staff determine the long term objectives for the client behavior in the problem area: what they would like the client to be doing eventually. Then, have them do steps 1 and 2 of the intervention form, writing down their responses. Help the staff define their behavioral observations into specific behaviors that can be reliably observed.

___5. Discuss the observation form that includes "before" and "after" conditions and events, and how it is used.

___6. Set up an appointment for reliability checks as soon as possible.

INTERVENTION FORM

Staff _____ Date _____

Client _____

1. Describe the problem. Ask yourself these questions:

   A. What behavior needs to change? Be specific.

   B. What positive behavior would you like to see? Be specific. Does this behavior sometimes occur now?

2. Observe the behavior to be changed

   Find out how often the behavior to be increased occurs and what happens or what conditions exist before and after it occurs by tallying this for a week using the OBSERVATION FORM, specifying the behavior and time periods. During the week also observe the problem behavior in the same way at least 2 times. Decide who is going to observe and record this information and when this will be done.

3. Analyze the behavior using the information obtained.

   A. What happens or what conditions exist just prior to occurrence of the problem behavior and its positive alternative behavior?

   B. What happens after the behavior occurs?

4. Plan the intervention.

Plan ways of changing any of the above "before" or "after" conditions or events so as to promote the desired behavior change, using the appropriate behavioral techniques (see attached checklist). Use the INTERVENTION FORM to chart the frequency of the client behavior to be increased and to chart staff behavior that is part of the intervention (eg. cueing, reinforcing) that occurs before or after the client behavior.

Be sure to indicate who is to do what, and when it is to be done. Also, work through any obstacles that may interfere with the success of your intervention.

INTERVENTION FORM (ESP 9/10/86)

CLIENT_____

dates/ times	BEFORE specify:	BEHAVIOR specify:	AFTER specify:

OBSERVATION FORM (ESP 9/10/85)

CLIENT_____

dates/ times	BEFORE Staff Observations	BEHAVIOR specify:	AFTER Staff Observations

Increasing Desired Behavior

1. Describe the problem. Ask yourself these questions?

Whose behavior needs to change?

What behavior needs to change?

When does this behavior(s) happen?

How often does this behavior occur? (Tally this for a week or ask a family member to keep the record or just ask how often it happened last week.)

What positive behavior(s) would you like to see? Do they happen once in a while now?

2. Ask the older person to engage in the desired behavior, then wait to give him/her and opportunity to begin (about 30 seconds). Don't rush. Limit what you say and make you instructions very clear. The prompt can be repeated once or twice but wait a while and see what happens.

What happened?

3. If the behavior occurred, tell him/her exactly what you liked about what they did. The more specific the better. You might want to include a treat such as a cup of tea or snack following a successful session.

What did you do?

4. If older person did not comply after above procedure offer a little help and praise any attempt to follow your instructions. If this works you may be able to reduce your help later and praise older person for working independently.

5. Chart your results and share it with the family or ask family to work with you.

6. If this doesn't work or if the person has serious dementia, choose one simple behavior and repeat the above procedure.

Decreasing Undesirable Behavior

1. Describe the problem. Ask yourself these questions?

Whose behavior needs to change?

What behavior needs to change? Describe what the client does?

When does this behavior happen?

How often does this behavior happen? (Tally for 1 week.)

Chose a behavior you would like to increase while you are working on the negative behavior so you won't decrease attention to the older person and cause them to become upset.

2. Begin to pay attention to positive behavior frequently. (Tally your attention to good behavior.)

3. <u>If you are giving older person lots of praise for good behavior</u> start ignoring the negative behavior you have defined above. Count to 10 to youself by saying one thousand, two thousand, etc.) After you have done this then wait a minute or so and go back and praise client for <u>anything positive</u> even if it is only sitting still. (Tally your ignoring as well as positive behavior.)

4. Chart your progress and share with family if you like.

Incontinence or Bowel Accident

1. Determine Problem

   A. Difficulty finding bathroom (night/day)

   B. Difficulty with clothing

      Won't cooperate with removal

      Can't remove clothing because of disability

   C. Toilets in inappropriate place

      Wrong position on toilet seat

      Urinates or deficates in wrong place such as closet or waste can

   D. Client can't discriminate or is unaware that they need to eliminate

2. Determine who will help with toilet and teach them to use one of the following procedures.

3. Interventions

   A. For difficulty finding bathroom

      1. Place tape on floor or wall leading to bathroom.
      2. Nightlight
      3. Sign or picture on the door.

   B. Difficulty with clothing

      1. If client is resistant or afraid (B1) be very conforting and explain exactly what you are doing. Do not start to remove items of clothing without saying what you are going to do first. Explain in terms of helping. Be as gentle as possible.

2. Suggest simple clothing for client to wear such as jogging clothes for men and women or clothing designed for diabilities with easy fastners.

C. Toilets in inappropriate place

1. Toilet seat in proper position.

2. Suggestion that person needs to go to bathroom when they start to inappropriate place such as closet or waste can in the kitchen.

3. Lock closet where inappropriate elimination occurs.

4. Take client to the right place on a regular schedule.

5. Remove waste basket from toilet.

6. Praise correct toilet use.

D. In general a two hour routine reminder is a good procedure for indivduals who experience bowel accidents this is especially for people with discrimination problems (D). Again praise compliance with schedule and appropriate toilet use. If client is cognitively able, the toilet schedule should be arrange with then and a schedule posted help the monitor their own toilet habits.

SESSION 12: INDIVIDUAL CONSULTATION

___1. In this session each staff member will develop an intervention. They will use the behavioral techniques they have learned, the information they have gained from their observations, and any other observations or ideas that they may have about those things that may be affecting both the client's desirable and undesirable behaviors.

___2. Review the staff's Observation Form.

___3. Read point #3 of the intervention outline and have the staff complete it. Explore conditions related to the behavior, using the Observation Guideline (give Guideline to staff).

___4. Read point #4. Read the Behavioral Intervention Techniques Checklist. Have staff look at the Intervention Form.

___5. Have staff complete step 4, writing down the treatment plan in all its relevant details.

OBSERVATION GUIDELINES

Here are some questions to ask yourself when observing and collecting data.

BEFORE:

1. Are there any obstacles to the client's performing the desirable behavior? These obstacles may be in the environment, within the client or something that others are doing.

2. Is there anything that is triggering or cueing the undesirable behavior?

3. Are there enough cues for the positive behavior?

AFTER:

1. Are there any negative consequences of the desirable behavior?

2. Are there any positive consequences of the undesirable behavior? (It may be possible to use these to reinforce the desirable behavior.)

3. Are there enough positive consequences for the desirable behavior?

BEHAVIORAL INTERVENTION TECHNIQUES

___ Reinforcement

___ Task Analysis

___ Cueing

___ Contracting

____ Reinforcing incompatible behavior. Note: Only use this technique if you are giving the client lots of praise for good behavior so that you won't decrease attention to the older person and cause him/her to become upset.

___ Skill recovery and development (incorporating all of the above)

SESSION 13: INDIVIDUAL CONSULTATION

___1. Review the progress of the intervention. Discuss any problems and revisions as necessary.

___2. Explain the purpose and technique of graphing.

___3. Have staff graph data. (Assist as needed.)

___4. Help staff prepare Intervention Form for the coming week.

SESSION 14: INDIVIDUAL CONSULTATION

___1. Review the progress of the intervention. Discuss any problems and revisions as necessary.

___2. Have staff graph data. (Assist as needed.)

___3. Help staff prepare Intervention Form for the coming week.

SESSION 15: INDIVIDUAL CONSULTATION

___1. Review the progress of the intervention.

___2. Have staff [illegible] data. (Assist as needed.)

___3. Discuss methods for maintenance of improvement over time.

___4. Discuss the effectiveness of the intervention. Highlight achievement by staff members.

___5. Present certificates.

___6. Terminate staff training sessions.

_____

Successfully Completed the Behavioral Management Training Program

of the

Elderly Support Project

Social Service Administration, The University of Chicago

Date_____

_____

Project Director

_____

Principal Investigator

)136

APPENDIX E

Family Training

Sessions 1-4

SESSION 1

1. Introduction of trainers and caregivers
2. General statement of purpose
   a. Overview of sessions
   b. Overview of our expectations: what we will ask them to do
      1. homework
      2. data recording
      3. pretests, posttests
   c. questions and answers
3. Pretest
4. Orientation: focus on increasing positive behaviors, how to view a problem as its positive alternative to be increased, examples.
5. Identifying target behavior for each caregiver to focus on: each have two possibilities in order of significance.
6. a. Purpose of observation and what is observed before and after, introduce concepts of cueing, consequences, reinforcement.
   b. Provide caregivers with observation forms.
   c. Discuss how to do observations and show examples.
7. Each fills in observation form and describes how they will use it. Trainer offers reinforcement and suggestions as needed.
8. Questions and answers.
9. Any business related to next session.

Forms needed for sessions:

observation forms

intervention forms

intervention methods handout (as in point #3 of session 2)

graph paper

Session 2

1. Discuss caregivers' observations and go over data collected. (we collect)
2. Trainers and caregivers discuss before and after factors observed by the caregiver that could be changed to increase desired behavior. If the observation material is insufficient, review the original discussion of what to look for when doing observations (point 6c of session 1).
3. Caregivers are given the intervention checklist, which trainers and caregivers go over together.
4. Trainers and caregivers select appropriate interventions.
5. Caregivers are given intervention form. Discuss how it is to be used.
6. Caregivers fill in form regarding own interventions and they describe how they will do the intervention. Trainers offer suggestions and reinforcement.
7. Questions and answers.
8. Business.

SESSION 3

1. Review caregivers' intervention and review intervention data. (Collect data.)

2. Help caregivers to revise intervention, if needed.

3. Using graphs made by trainers, have caregivers graph data, and discuss. Give them extra graphs to graph subsequent data.

4. Give caregivers additional intervention forms.

5. Questions and answers.

6. Business.

Session 4

1. Discuss caregivers' progress and go over data collection (we collect it)
2. Offer reinforcement and suggestions
3. Graph progress.
4. Discuss maintenance plan.
5. Discuss posttest in home and make appointment.
6. Questions and answers.
7. Business and conclusion and termination.

OBSERVATION FORM (ESP 9/10/86)

CAREGIVER _____ CLIENT _____

dates/ times	WHAT HAPPENED JUST BEFORE THE BEHAVIOR OCCURRED	THE BEHAVIOR YOU ARE OBSERVING specify:	WHAT HAPPENED JUST AFTER THE BEHAVIOR OCCURRED

INTERVENTION FORM (ESP 9/10/80)

CAREGIVER_____ CLIENT_____

dates/ times	WHAT YOU DID TO BRING ABOUT THE BEHAVIOR	THE BEHAVIOR YOU ARE INCREASING specify:	WHAT YOU DID JUST AFTER THE BEHAVIOR OCCURRED

CHECKLIST OF THINGS TO DO

(DO JUST THOSE THINGS THAT YOU HAVE CHECKED OFF)

____A. CUEING DESIRED BEHAVIOR. This is anything you say or do or provide that helps the client know when to do the desired behavior. These may be:

1. verbal, such as instructions or requests;

2. nonverbal, such as gestures or nods or "modeling";

3. environmental, such as signs or posters or where furniture is placed, and so on.

____B. REINFORCING DESIRED BEHAVIOR. This is anything you do during or after a behavior occurs that makes it more likely that the desired behavior will happen again in the future. These may be:

1. social, such as praise or touching or positive attention, and so on;

2. material, such gifts, treats, and so on;

3. opportunity to do something that the person likes to do.

____C. IGNORING UNDESIRABLE BEHAVIOR. This is your way of dealing with those behaviors that are to be reduced or eliminated. It is important to remember that if you use this procedure, it must be used with A and B, above, CUEING DESIRED BEHAVIOR and REINFORCING DESIRED BEHAVIOR. It should not be used by itself. Also, it should not be used at all for those behaviors that may cause injury or harm to the client or to others.

____D. CONTRACTING FOR DESIRED BEHAVIOR. For our purpose, a contract is an agreement between you and the client stating what he or she will do and what you will do, and what the client will receive for fulfilling the agreement. These work best when they are written and when they are simple and specific.

____E. TASK ANALYSIS. This is breaking down a behavior that has several steps or components into steps or components that can be followed by the client.

____F. CHANGES IN THE PHYSICAL ENVIRONMENT. This involves changing things in the physical environment to promote desired behavior.

A CARE PACKAGE

An assortment of behavioral strategies can make it possible for the most careworn caregiver to carry on.

BY CHERYL SIMON

PHOTOGRAPHY BY LAURA SCHAIR

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ED KUSPISKI ENTERED retirement eager to get on with travel and leisure pursuits long given short shrift. But it didn't work out as he planned. His friends started moving from the close-knit Chicago community they had shared for decades. He grew depressed, a response his wife, Sophie, recalls as the first step downhill.

In fact, a lot of things caught up with Ed. His emphysema, coupled with depression, sapped his strength, and he eventually suffered from erratic, uncontrollable trembling of the limbs similar to that in Parkinson's disease. Ed stopped playing cards and lost interest in sports. Instead, he smoked cigarettes and stayed in bed. By the time a hospital psychiatry unit referred the Kuspiskis to the University of Chicago's Elderly Support Project, Ed was severely depressed, despite heavy doses of antidepressant drugs, and his wife was worn out by the strain of caregiving.

Ed's problems, of course, changed Sophie's life too. She had expected increased freedom in retirement. Instead, she shouldered caregiving responsibilities most often described in terms of burden. "Every day, I gave him his bath, shaved him, fed him," she says. Like hundreds of thousands of people, Sophie never questioned her role as caregiver. Instead, she sighs, "It happened. There was nothing you could have done about it. All my care, and he's gone anyway. That's what really hurts."

As the population ages, more and more of us will be called upon to care for a frail elderly relative (see "The Myth of Abandonment," this article). Caring for an ailing spouse often occurs, as it did in Sophie's case, when the caregiver is advanced in years. But people sometimes are tapped for a caregiving role when they reach middle age and find that their aged parents need looking after. Gerontologist Elaine Brody of the Philadelphia Geriatric Center estimates that well over five million Americans spend part of their day taking care of ailing or dependent parents. The duties assumed can range from assistance with transportation and shopping to help with personal hygiene to 24-hour home care.

Caring for a frail, elderly loved one can test the most dedicated and stalwart of souls. The stresses range from the emotional to the physical—from unreciprocated comforting and nurturing to changing clothing and bedpans. As a woman caring for her sister, who has Alzheimer's disease, puts it: "She does everything. And if I tell her to wash her arm, she may wash her face. So I lift that arm, I do it myself and I feel guilty. I think to myself, 'Do you mean to tell me I've got to constantly sing that song: Wash under your arm, wash your face?' It's a strain on me. I keep saying, Lord, don't let me lose my temper."

The demands and chores of caregiving often leave little time for other activities, and the caregiver finds himself, or (more often) herself, isolated. Often the principal caregiver finds other family members unwilling or unable to share the load. The woman who cares for her sister explains: "She's got two other sisters, three children, a granddaughter, but they have no time for her. There's nobody but me."

0145

Caregivers experience subtle but sweet rewards for caring for frail loved ones.

(OVERLEAF) Sophie Kusinski displays a cherished anniversary photograph of her and her late husband. Left, Elsie Pinkston talks with Lola Kramer about her experience caring for her husband, Rudy (right), who has Alzheimer's disease. When Rudy realized he was losing his memory, Lola recalls, "He said, 'Someday I won't know anything, and I'll be happy. You've the one I feel sorry for.' But I feel very fortunate he's here with me."

Despite the obvious need, family caregivers generally make scant use of community services such as adult day-care centers and respite care. When sociologist Linda K. George and social worker Lisa Gwyther, both at Duke University, looked at the status of 380 caregivers during a one-year period, they found that fewer than one-fourth of the caregivers received any kind of formal service other than physician care for the impaired relative. Adult children, they report, are more likely than spouses to use support services and, indeed, to place the frail parent in a nursing home. Use of support services by elderly wives is especially light.

The reason, George explains, isn't insufficient current income—it's fear of poverty. Caregivers, especially spouses, she says, face an uncertain future. The patient's illness may go on for years, entailing huge unknown medical expenses. Nursing home care quickly drains even the most carefully filled family coffers. Some states still have spend-down rules that require a couple to count its financial resources and property toward nursing home fees until only $1,800 to $2,400, depending on the state, remains. Only then may the relative be eligible for institutionalization covered by Medicaid. A tragic result of this controversial practice is that the caregiving spouse, most often a woman, then faces old age and potential illness with no financial cushion. Then, she tries to fend for herself for as long as she can.

Happily, the news for caregivers is not all bad. With the tremendous increase in the population over age 65, and over 85 in particular, psychologists and social workers are stepping up their study of caregiving. While it is true that caregivers are often under considerable strain—in many instances, they find themselves isolated from friends and acquaintances, troubled by financial and health problems and feeling resentful and depressed—there is another, more positive side to caregiving. Sophie Kusinski, for example, can fight past her memories of fatigue and feeling unappreciated to arrive at an invaluable nugget of pride: She did what was needed, she took care of her mate. And her husband died at home, not among strangers in an institution.

Sophie is not alone. Researchers are discovering that many caregivers experience subtle but sweet rewards for caring for frail loved ones. They also find that they can teach caregiving skills that may lighten the burdens of caregiving and enhance the rewards.

This new emphasis on the positive side of caregiving arose in part through the efforts of Elsie Pinkston, a behavioral gerontologist at the University of Chicago who launched the Elderly Support Project almost 10 years ago. "Instead of looking at what's wrong in the caregiving situation, we decided to see what's right," Pinkston says. "Caregiving is so difficult, we started wondering, 'Why do they do it? What do they get out of it?'"

The first observations were casual. Every caregiver, it seemed, was the only one who could do the job. One was Mama's favorite, another was the only one who understood her. One did it because she was the oldest, another because she was the youngest. In short, the caregivers believed that they were endowed with something special that qualified them for the caregiver role.

Such reports showed why the caregivers believed they took on the role, but they provided rationales, not answers. Intrigued, Earlie Washington, an associate of Pinkston's and current director of the Elderly Support Project, began to gather supporting data. For starters, she interviewed 22 black caregivers of elderly relatives with Alzheimer's disease or related diagnoses about the rewards of caregiving. From their answers, Washington identifies three essential motivations—that caregiving makes people feel that they're fulfilling their obligations as a relative, that it makes them feel useful and that by helping someone else, they might merit the care of others when they themselves are old and frail. The opposite avenue brings others to their caregiving role: Caregiving allows many deliberately to avoid a quite painful consequence such as the potential guilt that they didn't do their part, or that they failed a relative who once cared for them.

Still, a question remains: Why do some caregivers maintain high levels of care with little stress, while others all but crumble under the strain?

The researchers suspect that some people experience high satisfaction because they define their situations more in terms of fulfillment than sacrifice. "These people don't feel burdened," says Washington. "They feel *privileged*." The notion that there are positive aspects to caring for the frail elderly led workers at the Elderly Support Project to devise ways to help caregivers identify and increase (or in some cases, introduce) desirable qualities such as affection, companionship or cooperation from those who receive care. They also find that those who receive care may again provide something in return. Patients can sometimes regain their ability to express appreciation, to carry on a conversation and, literally, to hold their benefactor's hand. Ideally, the changes make it easier for caregivers to carry on their roles.

The tools are the familiar stuff of behavior modification, particularly rewarding appropriate behavior and ignoring inappropriate behavior. The success of such techniques in correcting behavior problems in children is well known. Until recently, however, the methods have been little used with aged clients, even though some researchers find that in cases where a family caregiver is available, behavior problems resulting from brain damage and chronic illness are the most likely reason for nursing home placement.

Many such placements, however, are premature because family members and physicians assume the problems are permanent. A critical time is after an illness, because a well-meaning relative may adopt caregiving roles and never relinquish them. An older person, experts say, may come home from the hospital needing help with dressing or bathing. But if caregivers continue to do things the elderly person could do they are actually providing attention, a powerful reward for helplessness.

"An older person may just need to be dependent for a while without having someone move in and take

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Many women now caring for parents will care for dependent husbands in the future.

Sophie and Stella, left, and Jimmy, left, attend the Southwest Adult Day Care Center in Evergreen Park, Illinois. Right, Dorothy Gibbs encourages a participant in the Chicago Commons Adult Day Care Center.

THE MYTH OF ABANDONMENT

FROM THE TIME we are young, we soak up a pervasive myth and accept it meekly: People used to care for their elders but we, callously, will abandon our parents in old age, just as our children will abandon us. The persistence of this myth is remarkable because of overwhelming evidence that the opposite is true. Not only are more people—many of whom are old themselves—caring for their aged parents, but they are providing care for more difficult problems and for longer periods than ever before.

A recent congressional study reported that family caregivers provide between 80 and 90 percent of medically related care, personal care, household maintenance and assistance with transportation and shopping needed by older people. What's more, the duration and extent of care have changed since "the good old days." Whereas people typically used to care for parents during an acute, ultimately fatal illness, people today live long after chronic disease and disability set in. "It is long-term current care that has become the norm—expectable, though usually unexpected," says Elaine Brody of the Philadelphia Geriatric Center.

Some researchers equate parent care with other developmental stages that occur in the normal course of life. It differs, however, in that parent care is not linked to specific age periods. Need for parent care may arise as adult children rear their own young, as they enter and advance through middle age or as they adjust to the realities of their own old age.

Unfortunately, despite benefits such as companionship, feelings of usefulness and improved senses of self-worth, many people find that stress is a threatening companion to their caregiving responsibilities. Studies repeatedly identify emotional strain as a widespread and deeply felt consequence. Shifting roles and competing demands for time disrupt comfortable balances in both the caregiver's workplace and at home. Relationships between husbands and wives, among adult siblings and between adult caregiver and younger offspring must be adjusted, often for long and indefinite periods during which the needy relative is likely to grow ever more dependent.

Sociologist Samuel H. Preston, of the University of Pennsylvania, reports that for the first time in American history, the average married couple, by the time they are 40 years old, has more parents than children. While many men, particularly spouses of the care recipient, readily fulfill caregiving roles, the job overwhelmingly falls to women. Authorities believe this reflects acceptance by both men and women of traditional sex roles, rather than the sons' deficient sense of responsibility. Daughters are twice as likely as sons to become primary caregivers, and when the son is the official caregiver, the daughter-in-law often assumes the caregiving tasks.

The potential for conflict is especially great for Brody's so-called "women in the middle" who are squeezed between dramatic demographic shifts and changes in women's life-styles. Many women in this generation are mothers and are employed in addition to their responsibilities as primary caregivers. Given the sex differences in life expectancy, experts say that many of these women will care for dependent husbands in the future.

As family caregivers mete out untold hours of parent care, why don't they feel they are doing enough? Why do they continue to believe that most elderly parents are abandoned and that their children, in turn, will abandon them? Why does the "myth of abandonment" persist?

"The myth does not die because at its heart is a fundamental truth," Brody suggests. "At some level, members of all generations expect that the devotion and care given by the young parent to the infant and child should be repaid in kind when the parent, now old, becomes dependent." But that level of devotion is not possible for most adult caregivers, and consequently they feel guilty. The good old days, she explains, may not be an earlier period in our social history but an earlier period in each individual's and family's history to which no one can return. "Not only does the myth persist because the guilt persists," she says, "but the guilt persists because the myth persists."

over his life," Pinkston says. As people stop making demands, the elderly person has fewer opportunities to earn praise and other rewards of social interaction and becomes increasingly isolated. In response, the older person may either withdraw or act out verbally or physically in ways that are unacceptable. If the caregiver rewards such behavior with attention, treats or privileges, the problems become worse.

This seems to be what happened with Walter Ford (a pseudonym). Following a series of strokes, he frequently accused his wife of hiding men in the spare room, staying out all night and "being a whore." His tirades so distressed Mary Ford that she considered placing him in a nursing home. "What better way to get attention than by calling this sweet, white-haired lady a whore?" asks Pinkston. Project participant Glenn R. Green, now with the Proviso Council on Aging in Bellwood, Illinois, taught Mary to record the frequency and duration of her husband's accusations and to note her responses. Then she learned to ignore her husband's accusatory outbursts and to praise and touch him when he said more appropriate things. The tirades grew shorter and less frequent. Walter continued to live at home.

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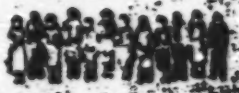
Caregivers

In 1982, 2.2 million unpaid caregivers assisted noninstitutionalized frail elderly people with one or more activities of daily living, such as dressing or eating.



72% were women.
29% were adult daughters.
23% were wives.
13% were husbands.

Kinds of Assistance

87% helped with personal hygiene

59% helped administer medication

46% helped with indoor mobility

80% helped with household tasks

59% helped with financial matters

Who Received Help?

In 1982, about 1.6 million noninstitutionalized disabled elderly people received and received assistance with one or more activity of daily living.

60% were women.
51% were married.
41% were widowed.
40% lived with spouse only.
36% lived with spouse and children or children only.
11% lived alone.

One-fifth of care recipients were age 85 years old.
Mean age of care recipients was 78 years old.

Competing Demands

31% of caregivers were employed

About 9% left their jobs to care for elderly people.

59% of [illegible] in the labor force.

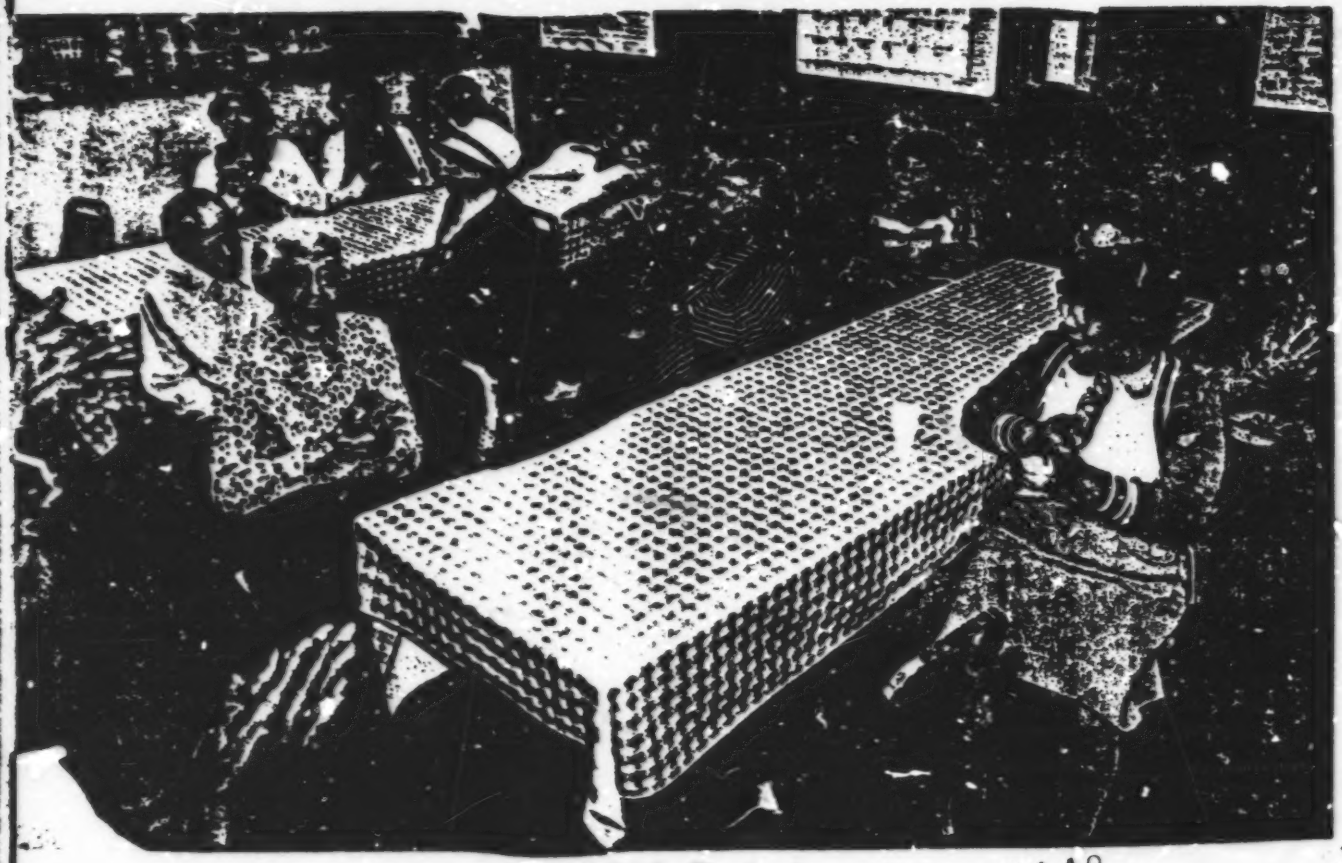
44% [illegible] the labor force.

Average Age of Caregivers

65% [illegible] years

28%

Compiled from data gathered from the Informal Caregivers Survey, a component of the 1982 National Long-Term Care Survey conducted by the Bureau of the Census for the Department of Health and Human Services.



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CRAFTS EARTH SURFACE GRAPHICS

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Even slight improvements help families avoid placing their frail relatives in a nursing home.

Members of the Chicago Commons community join in a spiritual round of hymns before lunch: "How much will it cost if I have to bear a cross?"

A GUIDE FOR FUTURE CAREGIVERS

WHILE CAREGIVING has its rewards, there's no getting around the fact that it entails hard work and carries the potential, ultimately, for sorrow. Here are a few steps that experts say may help lighten the load as families prepare for caregiving roles.

First, talk to your parents and spouse before a crisis occurs. Find out while they are still healthy what they expect from you if sickness and age make them dependent on others. Would they prefer to be placed in a nursing home? Would they rather live at home under your care? What are their preferences regarding life support? Ask them to specify their wishes clearly, preferably in writing, so that you and other relatives will know that your decisions conform, if possible, to the frail elderly person's wishes.

Second, if a general practitioner tells you your relative has Alzheimer's disease or senile dementia, seek a complete evaluation by a specialist in geriatrics. Many reversible conditions, such as depression, treatable forms of dementia and side effects of drugs, are easily mistaken for Alzheimer's disease. When Alzheimer's disease is suspected, a second opinion is always a good idea.

Third, beware of ageism, the tendency to dismiss treatable conditions as the inevitable result of age. Physicians, family members and the impaired elderly themselves often fall into the ageism trap. Physical problems and even confusion may respond to medical or psychological treatment. Some problems may be unrecognized side effects of medication or combinations of drugs. Challenge your physician.

Third, learn how to ask for help. Be specific. Instead of, "You don't help me enough," try "Will you take Father to the doctor at 2 o'clock on Tuesday?" Often, experts say, the problem is not that family members are unwilling to help, but that they don't know how to give it, and the caregiver does not know how to ask.

Finally, become familiar with community resources. There may be day care centers or other facilities in your neighborhood; some may be free or inexpensive. Most communities have local government offices on aging. These may be found in the telephone book under government listings. A list of state agencies is available from the National Association of State Units on Aging, 2033 K Street, N.W., Suite 304, Washington, D.C. 20006.

Similar techniques have helped caregivers overcome a number of problems. The researchers involved in the Elderly Support Project have seen the ailing elderly improve in personal hygiene, help out more with household chores and interact more with others. They've also found that bizarre language, emotional outbursts and physical aggressiveness succumb to apt use of behavior modification. Psychologists Louis and Kathryn Burgio of the University of Pittsburgh School of Medicine have shown that even incontinence, a troubling problem that frequently precipitates confinement in a nursing home, often can be treated successfully by biofeedback training and by scheduling visits to the bathroom at regular, say, two-hour, intervals.

Caregivers increasingly find relief through the adult day-care centers that are springing up all over the country. The centers are both private and public and range from plush, well-appointed suites in hospitals to modestly furnished but cheerfully decorated storefronts.

The Elderly Support Project staff is helping nursing home and adult day-care center staff members expand their use of behavior-modification techniques. Participants benefit too. For instance, at an adult day-care center operated by the Chicago Commons Association, Sally Jones (a pseudonym) at first refused to join in any activities. The staff lavishly praised her for any show of interest and gradually, says director Dorothy Gibbs, Jones began to participate. Soon she realized that the activities could be fun. Now Jones square dances, exercises and sings in the day-care center choir.

The staff revels in the beauty of such turnabouts. "Sometimes when people come here," Gibbs says, "they're so down they just want to die. But when they start getting involved, they start feeling good. They have a reason to get up in the morning, they have something to look forward to."

Pinkston says that behavioral techniques often enable families to delay or avoid placing their frail relative in an institution. Even slight improvements can make a world of difference. "We ask, 'How can an environment be improved to sustain a frail older person with some quality of life?' There is always some aspect that can be increased to improve the situation for both caregiver and care-receiver," says Pinkston. "The fact is, behavior modification works quite well if you can get people to use it."

It worked for Ed and Sophie Kusinski. With the help of Pinkston and psychologist Nathan Linsk, now at the University of Illinois, Sophie learned to use behavior-modification techniques. She was able to continue caring for Ed and to improve his quality of life at the same time. Ed became more active and smoked less. Life became a little easier, a little richer for both of them. And, for awhile at least, Sophie had her husband back.

Cheryl Simon is an associate editor at Psychology Today.

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